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Save the Children

Nepal Field Office

Empowering Families to Promote Child Survival

Nuwakot District
Ilaka 1, 12, 13
Central Development Region

Detailed Implementation Plan

Child Survival 8

September 30, 1992 - September 30, 1995

Grant #: FAO-0500-A-00-2034-00

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DIP TABLE A: COUNTRY PROJECT SUMMARY

PVO/Country: Save the Children/Nepal Project Duration (mm/dd/yy) start date: 1 O/1/92 estimated completion dais: 9/30/95

1. BUDGET SUMMARY IN U.S. DOLLARS

(a) a. By year of project	(b) A.I.D. Contribution (field + HQ)	(c) PVO Contibution (field + HQ)	Total Contribution (field + HQ)
Year 1	136,166	63,415	199,581
Year 2	143,139	36,573	179,712
Year 3	132,943	37,429	170,372
Country Project total	412,248	137,417	549,665

b. Percent of PVO Match: 25%

(PVO Contribution divided by Total Contribution: sum of column "c" divided by the sum of mlumn "d")

2. SIZE OF THE **PROTENTIAL** BENEFICIARY POPULATION

Note: POTENTIAL BENERUAHES are Mined" those In the project area who us eligible to receive services for a given intervention, not the percent you expect to provide services to – which may be smaller than the eligible population.

(e) a. Current population within each age group*	(f) Number of Potential Beneficiaries
infants, 0–11 months	1,447
children, 12–23 months	1,288
children, 24–59 months	3,467
children, 60–71 months (if Vitamin A component)	1,643
females, 15–19 years (high risk pregnancy)	1,485
females, 20–34 years	4,228
females, 35–49 years (high risk pregnancy)	2,856
Other: 8–14 females	1,720
Other: men + women of reproductive age	16,000

b. Additional births	
Total estimated live births. years 2 and 3	3.040
c. Total Potential Beneficiaries	37,182

* Note: Females (ages 15-49) should only be included as potential beneficiaries where they are direct beneficiaries of services (for examkple, TT immunizations. or family planning services), and not for educational interventions (fur example, education on proper use of ORT)

3. CALCULATION OF A.I.D. DOLLARS per **BENEFICIARY** per YEAR

a. Total A.I.D. Contribution to Country Project (sum of column "b" in table 1, this page)	412,248
b. Total Potential Beneficiaries (sum of mlumn "f" in table 2, this page)	37,182
c. A.I.D. Funding per Beneficiary for Project (line a. divided by line b. in table 3, this page)	11.09
d. A.I.D. Funding per Beneficiary per year (line c. above divided by 3 years)	3.70

4. PERCENT OF TOTAL A.I.D. CONTRIBUTION by INTERVENTION

Place percentages in shaded areas only: percentages must add to 100%

INTERVENTION	Percent of Project Effort %	Percent of A.I.D. Funds %
a. Immunization	20	20
b. Control of Diarrheal Diseases	15	15
c. Nutrition Education	10	10
d. Vitamin A	2	2
e. Control of Pneumonia	3	3
f. Maternal Care/Family Planning	15	15
g. Malaria Control	0	0
h. Other (specify)	5	5
i. Other (specify)	25	25
j. Other (specify)	5	5
TOTAL	100	100

5. ACTIVITIES: Circle all activity codes that apply for each intervention

a. Control of Diarrheal Diseases
(1) = Distribute ORS packets
(2) = Promote use of ORS packets
(3) = Promote home-mix
4 = Promote SSS home-available fluids
5 = Dietary management of diarrhea
= ORT training
8 = Hand washing
Other _____
(specify)

b. Immunization
1 = Distribute vaccines
(2) = Immunize mother/children
(3) = Promote immunization
4 = Surveillance for vaccine
(5) = Training in immunization practices
Other _____
(specify)

c. Nutrition
1 = Distribute food
(2) = Provide iron, folic acid, vitamins
3 = Provide scales and growth charts
4 = Sponsor mother-to-mother breastfeeding/promotion support groups
5 = Conduct food demonstrations
8 = Counsel mothers on breastfeeding and weaning practices
(7) = Conduct group sessions
(8) = Training in breastfeeding and weaning
(9) = Training in maternal nutrition
10 = Training in growth monitoring
Other _____
(specify)

d. Vitamin A
1 = Vitamin A deficiency treatment
(2) = Vitamin A supplementation
3 = Vitamin A fortification
(4) = Vitamin A education
5 = Vitamin A food production
Other _____
(specify)

e. Control of Pneumonia
1 = Promote antibiotics
(2) = Health education
(3) = Improve referral sites
(4) = Training
Other - Smokeless Stoves
(specify)

f. Maternal Care/Family Planning
(1) = Distribute contraceptives
(2) = Promote exclusive breastfeeding to delay contraception
(3) = Promote child spacing or family planning
(4) = Antenatal care
5 = Promote malaria prophalaxis
(6) = Train TBAs in improved birth practices
(7) = Family planning training
Other _____
(specify)

g. Malaria Control
1 = Residual insecticides
2 = Larvaciding
3 = Provision of bednets
4 = Provision of commodities
5 = Treatment
6 = Health education
7 = Training
Other _____
(specify)

h. Other **Specify**

Female Literacy
AIDS/HIV Awareness
Early Childhood Education

SECTION B: LOCATION AND FORMAL AGREEMENTS

B1. The project is located in the Central Development Region, in Nuwakot District, covering Ilakas 1, 12 and 13. Nuwakot is a mostly rural mountainous district with some emerging peri-urban characteristics since it is located on the northern border of the capital city Kathmandu. The ethnicity is mainly Tamang, the largest Mongolian tribal community in Nepal, but one of the least developed in the country. Most depend on subsistence **farming** and nominal livestock rearing. The literacy rate is 17%.

Ilaka 12 is served by health posts at Sikharbesi (6,310 persons) and Samundratar (12,641); Ilaka 13 by Rautbesi health post (8,764); and Ilaka 1 by Sallemaian health post (20,691). These posts are about a day's walk from Kharanitar (see map in Appendix).

B2. Ilakas 1, 12, and 13 were selected for the following reasons:

1) Central Development Region has been selected as the AID/Nepal sector priority area. SC is currently implementing a multi-sectoral model for strengthening primary health care activities through a DPHO in one district each in the Eastern and Western Development Regions. Testing this model in the Central Region will yield important evidence of the appropriateness of this multi-se&oral approach.

2) Integration of health service delivery was first implemented in Nuwakot District in 1975. In the new National Health Policy 1991 coordination of all health services by the District Public Health Office (DPHO) is mandated and emphasized.

3) The Tamang are a disadvantaged tribe which have been generally neglected and overlooked by development efforts.

4) The proximity to Kathmandu has not evidenced improvements in health or socioeconomic development.

5) The rapid population growth and development of Kathmandu has had a direct impact on adjacent districts, like Nuwakot. As the urbanization of Kathmandu will accelerate in the coming decade, gaining experience in peri-urban areas is appropriate.

6) Many adolescent girls and women from the proposed project area are recruited for trafficking to Indian cities for prostitution. This situation highlights the low status and lack of opportunity for women in the area and places these women and the general population at increased risk for STDs, including HIV infection.

Men engaged in migratory wage labor also compounds the problem of HIV transmission.

The constraints which are unique to this area are:

a) the lack of health infrastructure;

b) villages are geographically scattered with large distances between houses;

c) conservative attitudes;

d) prostitute trafficking has occurred historically and has become a tradition in the area amongst the Tamang. Extreme poverty is a primary cause for the "selling of girls". Bombay returnees are more affluent and socially acceptable. They often proceed to advocate

the path of prostitution for others.

In Ilakas 1, 12, and 13, the DPHO is responsible for the delivery of health services through the three ilaka health posts (HP) and one ordinary health post. These posts are inadequately staffed due the difficulty of posting staff to these remote areas. The lack of staff, supplies, and per diem limit the frequency of MCH clinics.

Each health post should employ six male Village Health Workers (VHW), one per Village Development Committee (VDC). They provide preventative and basic curative health services at the community level and supervise the 10 female Community Health Volunteers (CHVs) in their VDC. In Ilakas 1, 12, and 13, over half of the six VHW positions in each health post are vacant. Referrals from the health posts are made to the District Hospital at Bidur or hospitals in Kathmandu. Mothers' Groups were formed in each ward by the MOH staff to assist with the selection of CHVs. Several years ago, HP staff trained the CHVs to promote MCH and family planning and to provide minor curative services but lack of regular supervision and the withdrawal of a financial incentive has rendered many CHVs inactive. Traditional Birth Attendants (TBAs) have been trained by MOH staff (15 per ilaka) but supervision of the TBAs by the VHWs and HP staff is irregular.

B3. SC has established an informal, collaborative relationship with the DPHO in Nuwakot. SC has successfully negotiated a formal agreement with the MOH at the national level in January 1993. This agreement greatly enhances SC's ability to advocate for further MOH attention in the area.

SC has established collaborative relationships with other governmental and non-governmental agencies in Nepal, i.e.,. Ministry of Education, UNICEF, UNFPA, Royal Drugs, Contraceptive Retail Sales, Co., SC(UK), Redd Barna, World Education, JSI, Nepal Red Cross Society and will continue to work with these agencies during the project. Specific areas of collaboration include development of methods and materials for health education, logistic support for vaccine, ORS, temporary contraceptive methods, Vit A capsules, and technical and management training for DPHO/HP staff and community volunteers.

WHO has granted SC a one year project entitled "AIDS Education and Prevention Among Tamang and Lower Caste Communities in Nuwalcot District" to train local NGOs and DPHO in how to provide AIDS education and to raise awareness among the population about STDs, as well as establish peer counselling in high-risk communities. SC has also received a one year grant to work in coordination with the Institute of Medicine, SC (UK), Redd Bama, and the Division of Nursing (MOH) to test a safe home delivery kit for use in rural and urban communities in Nepal from UNFPA and UNICEF.

SECTION C: DIP SUSTAINABILITY STRATEGY

C1. SC aims to sustain the community demand for services and improved knowledge and practice of health protective behaviors at the household level. SC also aims to strengthen the delivery of health services by the MOH, however recognizes that support for improved access to quality health services may not be fully sustainable.

The CS 8 KAP survey shows that protective behaviors are low. Empowering families, especially women to promote child survival activities will require a major change in existing attitudes and behavioral patterns in these communities. Targeting the female members of these households through intensive and broad access to literacy classes will ensure a widespread village-level initiation into modem development and health issues.

The curriculum designed by the MOE is heavily based on raising the consciousness of

villagers to the social, economic and health issues of their daily lives. Supplementary curricula have been designed by SC to provide post-literacy materials, with special concentration on MCH issues. Women who graduate from the Basic and Advanced Literacy Classes will be formed into Women's Groups for savings. These groups will receive intensive training on leadership development and group organization, and be the basis for sustainable women's activities for years to come. Health education messages introduced during the course of the project in these communities will have a measurable impact on behavioral changes relating to child survival.

New educational programs for early childhood education will not only benefit children, but relieve their parents of the daily responsibility of childcare. By sharing this workload among members of their community it will expand their economic opportumty, as well as introduce the caretakers and parents (including fathers) into regular weekly evening classes to discuss education and health issues, under the supervision of a community member who will be trained by SC. These innovative education structures will be established by SC and the District Education Office (DEO), but rely on community management and participant's time allocation for its sustainability.

It is expected that CHVs, TBAs and mothers' group members will become stronger, more knowledgeable advocates for child and maternal health through attainment of basic literacy skills and training in communication of child survival messages. Group formation which emphasizes leadership and team work include: mothers groups, literacy groups, women's savings groups, child care cooperatives, parenting groups, etc. The three levels of sustainability are:

Individual Behavioral Change: A high level of community participation, especially of women, will ensure the long-term public health impact of these nonformal education systems. Individuals sustain behaviors when they perceive that these changes lead to lasting benefits which outweigh their financial and psychological costs. Behavioral change arising from increased and wide dissemination of knowledge leading to creating new community norms is the foundation of SC's strategy.

Institutional Strengthening: A major emphasis will be given to leadership training at the community level, and all facilitators for the basic literacy, advanced literacy, home-based child care centers, child-to-child classes, and parenting classes will be selected and trained from the local communities. Local group leaders will also be selected to receive intensive training for the mother's groups and women's groups in these villages and will receive support in establishing savings programs. Through this group methodology, individuals, families and whole villages will be empowered to participate in their local development process and demand the provision of latent public health services. Government workers, especially the community VHWs, CHWs and TBAs and the local NGOs in the area will also be strengthened through work with the project.

Policy Level: IEC methods and materials produced through this project, especially for AIDS awareness and prevention, will benefit national programs. SC will work with and share project findings among a wide variety of government agencies.

This project will present a multisectoral model for both MOH and MOE of service delivery systems that are low-cost and sustainable at the community, household and family level. SC will work closely with both the DPHO, DE0 and Nepali NGOS active in the area to establish or revitalize both education and health service delivery systems. SC staff will serve primarily as trainers. As this model is being tested in slightly different forms in districts in two other development regions of the country, this project will serve as an excellent opportunity for HMG to review its implementation strategies in three quite different contexts

of the country, Western, Eastern and Central Development Region.

SUSTAINABILITY OBJECTIVE

50% of all groups formed will be operating independently by Year 3. The groups include 126 Mother's Groups, 39 Parenting groups, 39 Women's Savings Groups, 39 Self-Help groups, 18 Home Based Child Care Center, and 28 MCH clinic management committees.

Mother's groups formed by **CHVs** at the ward level are a component of **MOH's** system but require revitalization. Mother's groups are formed as a health education forum whereby **CHVs** disseminate health messages. **Parenting** groups formed for fathers and mothers separately are a venue for learning about family life education, early childhood development and child survival behaviors. **Women's Savings Groups** are formed from members of the advanced literacy classes. The groups are trained in leadership and management skills and conduct various income generating activities such as vegetable gardening, social marketing of ORS and condoms, and producing weaning food ("super flour") to be sold at MCH clinics. **Self-help groups are** formed among the "poorest of the poor" and are provided with a subsidy up to 75% of an income generating activity in a group fund. **Home based Child Care Centers** are home-based day care in which mothers are trained in ECE and nutrition. **MCH Management Committees are** formed per MCH clinic (2 per VDC) and are comprised of the mother's group from the clinic site. They disseminate clinic schedules, decide location and logistics.

Monitoring of public support will be done through program supervisors (field coordinators) and activity reports of the various groups formed. Indicators include the number of groups functioning independently, the number of groups that have established linkages with concerned agencies, the number of trained workers in the local institutions and the number of groups that have requested loans (women's savings groups). Meeting minutes, cross checked with SC facilitator activity diaries will be used as monitoring tools. An assessment of the groups will be done during the MTE and also during the final evaluation.

C2. The community's priorities are literacy, health education, health services and controlling girls trafficking. In November 1992, a two day planning meeting of 25 local leaders from 14 VDCs displayed the community's desire to own the program and work in collaboration with SC. Major problems sited were illiteracy, lack of knowledge about CS behaviors and the frequent transfer of HP staff.

Ownership will continue to be fostered through local leader coordination meetings held quarterly. Local management committees will be formed for each mobile clinic, which the community has selected the sites thereof. Quarterly coordination meetings with DPHO will be held to discuss all health activities.

C3. Eleven DPHO liaison officers helped with this DIP. The Chief District Officer and the Chairman of District Development participated in a planning coordination meeting. Two small-scale Nepali NGOs are working in Kathmandu and nearby districts to promote the welfare of women. ABC Nepal ("Agro-Forestry, Basic Health, and Cooperatives") is coordinating efforts to establish a national policy on trafficking of girls to India and they are eager to work with SC. Srijana **Bikash** Kendra ("Creative Development Center") helps disadvantaged women and has opened a hostel in Nuwakot for women in crisis and transition, including prostitutes returning from India. They are interested in collaborating with SC in areas of common concern.

C4. Phasing over major program responsibilities and control to local institutions will occur as soon as the necessary skills have been demonstrated. Training in management skills of DPHO

staff will include a specialized course on "Where there is No **Doctor and Liited Supplies".**

C5. All the education and health activities identified in this proposal will require some private fund contribution by community members. All SC NPE classes require students to pay an entrance fee, and monthly fees, in addition to a partial payment for books and materials. Women's Groups formed by SC also require a membership fee and a specified monthly savings to be contributed to the group fund for loan activities.

SC's CS3 social marketing experience in **Gorkha** for temporary contraceptives and ORS will be tested in Nuwakot, given MOH approval, through TBAs and CHVs. SC has finalized discussions with **UNFPA/Nepal** to jointly test the marketing and distribution of safe birthing kits in the area. Senior CS3 and CRS company staff will be used as consultants to identify **CS3** cost recovery schemes to be transferred to Nuwakot.

The project staff will work with the DPHO, DE0 and local NGOs to identify ways to recover some of their costs, such as prescription fees, and the sale of ORS and temporary contraceptives. Already, Women's Groups formed by SC from literacy classes in other districts are functioning independently of the agency in maintaining their monthly savings requirements and in providing group members loans at interest rates similar to government banks. Private enterprise schemes such as the sale of weaning foods and safe birthing kits will be explored. Rabindra Thapa, Project Coordinator, will be responsible for overseeing the implementation of institutional development and sustainability strategies: .

SECTION D: PROJECT DESIGN

D1. The most outstanding findings of the CS VIII baseline K&P survey include:

6.6 % female literacy rate
1.4 % under-twos completely immunized
79.1% under-twos never been immunized
7.1% mothers with **TT** 2
91.9% mothers who do not desire another child & do not contracept
3.3 % households with a < 2 with a growth monitoring card
95.7 % mothers currently breastfeeding
43.8 % under-twos had diarrhea in the last 2 weeks
42.9 % mothers did nothing while child had diarrhea
17.3% mothers gave ORS (packet or salt-sugar solutions)
50.0% mothers correctly prepared ORS of those that gave ORS
77.6 % mothers either haven't heard of ORS or can't mix correctly
43.8% mothers who have observed ARI during the last 2 weeks
96.7% child with ARI last 2 weeks with rapid, difficult breathing
44.6% ARI cases but did not seek any treatment
0.0% children have been given Vit A supplementation

D2. Goal: Sustained reduction in infant, child and maternal mortality and morbidity by empowering families to address their health, educational and developmental needs and by creating an increased demand for improved government health services.

Objectives to be achieved by September 1995 are:

1) 40% of children 12 to 23 months will be fully immunized against BCG, DPT, polio, and measles; and 25 % of women between 15 and 45 years will be immunized against tetanus, by MOH norms.

2) At least one member in 50% of families with under-5 children will prepare ORS correctly, and 25% of children with diarrhea in the last two weeks will be treated with ORT (Jeevan Jal).

3) Female literacy rate increased to 30% of 15-45 year population.

4) 50% of men and women will be knowledgeable about three main modes of AIDS/HIV transmission and three protective behaviors.

5) 70% of mothers will know to give supplementary foods at four to six months.

6) 40% of under-five children will receive vitamin A supplementation every 6 months.

7) 25% of families will be competent at early detection of ARI and referral of cases to health posts for treatment.

8) 40% of mothers will know the three clean birth principles.

9) 15% of eligible couples will use any method of contraception.

10) 20% of families will be trained in healthy and stimulating child care practices.

11) 30 % of community groups formed will be operating independently.

Planned inputs: Management, technical, and trainer's/communication skills training for DPHO/HP staff; technical and communication skills training for CHVs and TBAs; communication skills training for NFE supervisors and facilitators, school teachers, Child Care Cooperative leaders and women's group leaders. Child survival messages will be widely disseminated by the abovementioned groups during a variety of person contacts: community presentations, meetings, classes, exhibitions, mass campaigns, and personal contacts. Developing relationships with MOH at the central level in order to tap available resources (and demand them). The linkages with the central government will be formed. A minimal health information system serving target groups will be developed with sample surveys reporting on outcome indicators. IEC methods/materials developed and used.

Planned outputs: Group formation of Mothers, Parenting, ECE, Child Care, Women's Savings, Self-Help, management committees; MCH clinics, STD camps, Vit A camps, EPI camps ('IT), and annual health exhibitions and Literacy classes (basic, advance and out-out-school classes).

Planned outcomes are reflected in the objectives above.

The KAP baseline survey was indispensable during the development of this DIP. Survey results were presented to local leaders and to District MOH personnel in November 92. As a group, the entire team of SC Nuwakot reviewed each of the findings and used the data as the launching pad for developing this plan during a 3 day workshop. Objectives set during the proposal stage were readjusted to reflect more realistically the community situation and targets were reset according to achieveability.

D3. Project Design: SC will work through the MOH and MOE to strengthen its capacity to deliver effective services to the rural areas. Trainings in community organization, supervision, communication, monitoring and evaluation will be provided to DPHO and DE0 staff. The project will emphasize the role of CHVs, TBAs and mothers' groups in created improved knowledge and practice of health behaviors at the household level. The baseline survey

showed unexpectedly low levels of child survival knowledge and practice. Key health interventions include: diarrheal disease management, with emphasis on ORT, continued feeding, training on hygiene and sanitation; and immunization, mobilizing families for timely, complete immunization coverage and supporting MOH delivery of active vaccines through training and improved cold chain maintenance. The nutrition intervention focuses on improving lmowledge and use of appropriate weaning foods. Maternal health activities include increasing access to and utilization of antenatal, postnatal, and family planning services through outreach clinics; and the promotion of clean delivery practices. Families will be trained in early detection and referral of ARI cases; HP staff will receive training in case management of ARI.

An important component of this project will be to empower families, especially women, through an intensive educational effort to raise literacy standards, as well as to introduce new forms of educational opportunity and motivation, e.g. home-based CCCs, Parenting Classes, Mother's Groups, and Women's Groups for savings and loans. These two mutually supportive components of the project will significantly increase improved child survival behavioral practices, project sustainability, community awareness of PHC programming and demand for government health and education services. Although the project will concentrate on the female population, emphasis is given to parenting classes for fathers as well, as the SC CS3 project in Gorkha has proven that increased awareness and understanding among fathers has had an important impact on family behavioral patterns. New IEC materials tested in this project will have potential use in national programs.

Innovative areas of the design include interventions regarding STDs and AIDS awareness/diagnosis and treatment camps, Parenting classes, child care cooperatives and child-to-child groups, all initiatives under the rubric of early childhood development. Resides group formation, "conscientization" of health behaviors through literacy classes is a major venue.

D4. Targeted beneficiaries will interface with this project through community level group formation. The inclusion of eligible women, children and newborns into the groups will be the responsibility of the first line worker at the ward level, the CHV. She will encourage participation within her area and maintain a roster of the beneficiaries. Diaries of activities will be kept by the CHVs and reviewed by VHWs and SC field health staff. MCH clinic data will be maintained using the MOH recording tools rather than creating a parallel system. Training in strengthening the use of data will be provided to DPHO staff.

Quarterly supervisory meetings between community management teams and SC staff and DPHO will occur to provide advice and guidance as well as positive reinforcement for work well done.

A midterm evaluation will be conducted in the summer of 1994 (month 18) along with a sample survey. A final evaluation will be conducted at the end of the project with a final KAP sample survey to compare results to the baseline. A matched case control study will be done to compare NFE participants' KAP in Child Survival with non-participants.

D5A. DIP FOR IMMUNIZATION (EPI)

5al. The baseline survey measured immunization coverage from documented coverage according to EPI cards. The rates for children 12-23 months are as follows:

19.5% with card	18.6% BCG	4.8% measles
11.4% Polio 1	11.0% DPT 1	2.4% complete
2.4% Polio 3	2.4% DPT 3	79.1% never imm.
78.9% Polio drop-out	78.1% DPT drop-out	
2.4% Complete coverage (BCG, Polio/DPT 123, measles)		
7.1% Mothers with a child < 2 yrs with at least 2 TI' doses		

5a2. Knowledge and practice regarding immunization of mothers of children under two years obtained during the KAP survey included:

46.7% mothers reported their children have received immunization
61.9% mothers answered incorrectly the age of immunization
79.5% mothers do not know why 'IT should be given
18.6 % mothers do not know the number of TT needed
19.5% mothers could show an EPI card for their child

5a3. MOH/EPI protocol recommends the following schedule: BCG: birth-l year, DPT/Polio 1: 6 weeks-l year, DPT/Polio 2: 4 weeks later, DPT/Polio 3: 4 weeks later, Measles: 9-36 mos.

The MOH recommendation stresses that children should receive all eight vaccines by the age of 12 months. The estimated beneficiary population for immunization is:

1,340 O-11 months
1,288 12-23 months
2,628 O-23 months
7,806 women 15-45 years
1,400 estimated new boms per year.

To provide full coverage each child requires at least five visits. Therefore, 7,000 visits will be needed for this population. As immunization coverage is considerably lower than expected, all women 15-45 years and children O-23 months are considered high risk for immunization.

5a4. The objectives for immunization are: 40% of children 12-23 month will be completely immunized and 25 % of women 15-45 years will have received at least 2 doses of 'IT. There is not a specific project objective regarding increasing mother's knowledge of immunization although it is necessarily inherent in the process.

TARGETS BY YEAR	Yr 1	Yr2	Yr3
Children 12-23 months	262	657	1050
Fully immunized	10%	25 %	40%
Women 15-45 years	770	1155	1950
2+ doses of TT	10%	15%	25%
Mobile clinics held	70	145	145
TT camps held	3	6	6

5a5. The immunization component will improve access to viable vaccines through management and technical training for DPHO/HP staff, cold chain support and logistic support

for MCH Mobile outreach clinics in 14 VDCs. VHWs will continue to provide immunization at 4 fixed sites per month. TT camps will be given twice a year.

Inputs are: * Collaboration with DPHO to improve immunization coverage through health post staff refresher training in cold chain maintenance, sterilization, immunization techniques, and supervision techniques. * Training of CHVs, TBAs, literacy class facilitators on the importance of timely and complete immunization and how to communicate immunization messages. * Improve coverage through ECE Intervention, Mother's Groups, Women's groups, School Health programs, parenting classes, EPI camps and annual exhibitions.

The activities will be carried out in all areas at once since there are SC health personnel assigned within each ilaka. Immunization services will be available all year given at both mobile and fixed facilities.

5a6. Nar Maya Subba, Deputy PH Coordinator is responsible for technical oversight of EPI. Quarterly monitoring of the progress in immunization will be conducted by Rabindra Thapa, Project Coordinator.

5a7. DPHO/HP staff will receive management and technical training to provide immunization services. Management training will be 8 days duration and will be given in April 93. DPHO and VHWs will receive EPI technical training of two days' duration. The training will focus on EPI logistics, included cold chain maintenance. This training will be given concurrently with two months of technical and clinical supervision of HP staff regarding delivery of MCH services. This supervision will be provided by a clinical specialist in MCH services.

CHVs and trained TBAs will receive one day of refresher training on immunization. The focus of the training will be on the importance of immunization, schedule, and the CHVs role in promotion of EPI. This training will be given quarterly.

A series of Child Survival communication skills training will be given to 5 DPHO and 4 HP staff and 14 VHWs for 12 days. These staff will then conduct communication skills training of six days duration for 126 CHVs, 126 TBAs, 313 NFE facilitators and 10 supervisors, and 130 mothers group leaders. These workshops will enable the participants to effectively communicate with community members about specific child survival messages, including EPI. The trainer's training will be started in July 1993, followed by the training of CHVs. DPHO/HP staff and CHVs will receive refresher training one year later for six and three days respectively. Their communication skills will be assessed at that time. The success of immunization training will be evaluated during supervisory visits during sessions as well as through increase in coverage rates.

5a8. The HP staff and VHWs will use the MOH EPI cards to record immunizations (see Appen. C). If a child's card is lost, the VHW record book will nonetheless record the immunization. The project will work with the DPHO/MOH to improve vaccine supply prior to providing cards. The MOH does not conduct mass campaigns. The MOH/EPI consultant and UNICEF officer have agreed to supplying cards and forms for the project.

5a9. In terms of childhood immunization coverage, the drop-outs will be identified by analyzing the HP records after each MCH clinic. CHVs will be encouraged to follow-up defaulters through home visiting during the course of the following month.

5a10. TT messages will be disseminated through many avenues, including schools, women's groups, MCH clinic, NFE classes.

5all. A thorough assessment of the cold chain by the Project Coordinator and HP in-charge

will be made in Feb. 93; however, it is already known that it is virtually nonexistent. There is no electricity nor Luxembourg boxes or freezers at this time. Monitoring vaccine temperature will be done by the **VHW** using a thermometer and record book. Cold chain equipment is available from UNICEF and MOH. If it is not adequate SC will purchase the balance.

5a12.Disease surveillance will not be carried out separately, however, the HP staff and SC workers will review HP records quarterly to determine causes of morbidity and mortality.

SECTION **D5b. DIP for DIARRHEAL DISEASE CONTROL (CDD)**

5b1. Diarrheal diseases are considered to be a leading cause of death in the district according to MOH staff. This is consistent with the National Diarrhea Disease Survey **(5-6/1985)** that reported that 71% of deaths among children 7-24 months were diarrhea-related. Lack of knowledge regarding sanitation, hygiene, and treatment of diarrhea contribute to the high frequency and severity of diarrheal episodes. The KAP survey revealed that 43.8 % of under-twos had a diarrheal episode in the last 15 days.

5b2. Current knowledge and practices of mothers of children under two years revealed in the KAP survey are: * 82 % of mothers breastfed as usual when their child had diarrhea, and 9% breastfed less; fluids were given as usual among 34% of mothers, and solids were given 37% * 43 % of mothers did not do anything, 12% gave packet ORS of which 50% mixed it **correctly.**

5b3. The MOH protocol for case management of diarrheal disease is: * early home-based prevention of dehydration through administration of extra fluids (breastmilk, soups) and small amounts of food to older children. * early home-based prevention of dehydration through administration of ORS. * Prompt referral to HP/hospital of children with diarrhea who do not respond to home-based treatment or who have signs of dehydration, fever or vomiting. * Assessment of rehydration status of children referred to HP/hospital and treatment with ORS or intravenous fluids * antibiotics (cotrimoxazole) are recommended only if there is high fever with abdominal pain,; metronidazole is recommended for diarrhea of more than two weeks duration. * mothers are counselled to give more fluids and continue small, frequent feedings of solid food during diarrhea; are given a demonstration of ORS preparation and advised on how to give ORS; and are encouraged to give extra food after recovery from diarrhea.

5b4. The objective is 50% of families will correctly mix ORS (Jeevan Jal) and 25% of families will use it in the last two weeks during diarrheal episodes.

5b5. The estimated beneficiary population for CDD is: O-11 mos: 1340, 12-23 mos: 1288, **24-60** mos: 3467 TOTAL: 6095 The approximate number of mother contacts will be 12 contacts, through mobile clinics, NFE classes, CCCs, mother's groups, exhibitions, etc. All children under two will be considered high-risk for management of diarrheal disease.

5b6. The CDD intervention will emphasize home-based treatment of diarrhea and prevention of dehydration according to the attached MOH protocol (see appendix). Families will be taught how to prepare and administer ORS; appropriate feeding practices during and after diarrhea (breastmilk, other home available fluids and foods); signs of dehydration requiring referral to the HP; and how to prevent diarrhea. **CHVs,** TBAS, schoolteachers, NFE facilitators and women's group leaders will be trained to share these messages in their communities. VHWs will provide supervisory support to the CHVs and TBAs encouraging them to promote early home-based treatment of diarrhea. The project staff will collaborate with DPHO to train the health workers. Mothers' groups, literacy classes, and ECE program participants will be provided with messages and demonstration in recognition and appropriate treatment of diarrhea (including continued breastfeeding, extra feeding during recovery, referral of severe cases),

prevention of diarrhea (including basic hygiene and sanitation), and communication of diarrhea treatment and prevention messages. The availability of ORS will be facilitated. ORT comers will be set up during MCH clinics as well as during NFE advanced classes.

5b7. Packets will be promoted, although the cereal-based rice water or porridge with salt will be encouraged as initial home fluid.

5b8. The exact measurements of ORS (Jeevan Jal) is one packet to one liter of water, six glasses of water or two mannas of water.

5b9. Case management at the HP is lacking. The training of HP staff will focus on assured availability of ORS and appropriate referral services. The simplicity of ORS preparation and the fact that it is free makes it less valued as a treatment. Focus group discussions will be held to mediate these beliefs.

5b10.Messages will include initiation of home fluids, continued breastfeeding, continued feeding and the mixing and administration of ORS. Messages developed through CS 3 program will be used in the project area. ORT comers at the mobile clinics, demonstrations during the NFE classes, demonstrations during mother's groups, parenting groups and CCC groups will be occasions to learn to mix ORS.

5b11.Strategies such as handwashing with soap and basic personal hygiene will be aspects of the control strategy.

5b12.The person responsible for the technical oversight of the CDD component is Rabindra Thapa, Project Coordinator. The health team will conduct an annual survey to monitor mother's knowledge of correct ORT. Three staff nurses (one in each ilaka) will supervise the quality of health workers' instruction to mothers (Ilaka 1: Netra 12: Maya Kumar 13: Bhim)

5b13.Training in CDD will be conducted for: 6 **DPHO/HP,** 24 **VHWs,** 126 CHVs, 126 **TBAs,** 313 NFE facilitators, and 130 Mother's groups. The training will be for **DPHO/HP** staff and will be part of the health training given for 8 days. **In** addition, 4 **DPHO/HP** and 14 **VHWs** will receive CDD technical training of one day's duration. The training will focus on promotion of early home-based treatment of diarrhea, including logistical support for distribution of ORS and appropriate referral and treatment. This training will be given concurrently with two months of technical/clinical supervision of HP staff regarding delivery of MCH services.

CHVs and TBAs will receive two days of refresher training on CDD/ORT. The focus of the training will be on the importance of early home-based treatment of diarrhea, including ORS and nutritional management of diarrhea, appropriate referral of cases, and the **CHVs** role in CDD. This training will be given in June 1993.

5b14.During the annual survey to determine mother's knowledge about ORT, mothers will be asked to demonstrate to the interviewer. The interviewer will have a checklist to monitor **performance.**

SECTION D5c. DIP FOR NUTRITIONAL IMPROVEMENT

5c1. Up-to-date estimates of nutritional status in Nuwakot are not available; however, a recent study of nutritional status in a district that borders Nuwakot reports severe malnutrition of 11% and moderate malnutrition of 28% (Action Aid Nepal, Poverty Indicator Survey: Final Report, 1991). According to a 1991 UNICEF report on "Trends in Nutritional Status since 1975", 4% of children 3-36 months were third degree PEM in Nuwakot district.

5c2. Food availability is fairly constant throughout the year, with rice, maize, millet, wheat, pulses and seasonal vegetables. The **KAP** survey revealed that 47% of families produce enough food for more than nine months of the year, while 24% had enough for 6-9 months and 28% did not have enough for more than half the year. Forty-two percent of families have fruit trees and 92% grow winter vegetables.

5c.3. At the time of the KAP survey, 95.7% of mothers were breast feeding, with only 2.9% ever bottle-feeding. Breastfeeding continues for 2-3 years or until the next pregnancy. Colostrum is commonly used. Solids are introduced at less than 4 months for 23.8% of mothers interviewed, whereas 39 % started at 4-6 months and 35 % started later than 6 months. Fifty percent of mothers mix additional fat (ghee) in their child's solid food. Weaning foods include dal-baht(rice and lentils) and "green vegetable lito". When a child is ill they are usually given less food.

Traditionally, girls at five months and boys at six months of age are introduced to solid foods at a rice feeding ceremony; however, the ritual does not guarantee that the child will continue to receive solid food as required.

5c4. The estimated beneficiary groups for nutritional interventions include:

Women's groups (15-45):	2,340
Mother's groups (15-45):	5,000
NFE classes (15-45):	3,580
Child to child: (8-16)	120
Child cooperatives:	150
Out of School program (15 -20):	1,500
Mobile clinics with ORT comers:	5,800
Parenting groups:	840

The amount of contacts per group which will be focussing on nutritional messages are approximately 6 per year. A "High-risk" profile for a child includes any of the following: a serious current illness; displacement by a younger sibling (or one coming), particularly for girls; failure to be immunized.

5c5. The nutrition objective is: 70% of mothers will know to give supplementary foods at 4-6 months.

5c6. The strategy for improving nutritional status of weaning age children is to provide adequate knowledge through training to mothers on when to introduce supplementary foods. The messages will be widely disseminated through the groups mentioned in **5c4.**

Inputs include training to all health workers **(VHWs,** CHVs **TBAs)** and HP staff regarding case management of severe malnutrition. Nutrition education and demonstration in women's groups, mother's groups, MCH clinics and NFE classes will be conducted to teach mothers about appropriate weaning foods and when to introduce them. Women's groups may choose to produce packets of weaning food (ready-toeat) and to sell at mobile clinics. The activities will be phased in with dissemination of nutrition messages being initiated in year two. Constraints in improving nutritional status lie in the underlying general poverty of the area and the widespread nature of the problem.

5c7. Low birth weight babies will not be addressed specifically.

5c8. The problem of improving the nutritional status of pregnant and lactating women will be addressed through nutrition education of mothers groups, women's groups, NFE classes and during MCH clinics.

5c9. Supplementary foods will not be provided.

5c10.Nar Maya, Deputy Public Health Coordinator will be responsible to technical oversight regarding nutrition.

5c11.The following messages will be promoted:

* More foods should be given to a child during and after illness
* Supplementary foods should be started at 4-6 months
* Demonstration of how to prepare supplementary foods

The media will be through food preparation demonstration and individual counselling during MCH clinics, and small group discussions during mothers groups, women's groups, and NFE classes. SC plans to develop appropriate materials for literacy classes and will perform street drama in promotion of nutrition practices.

VITAMIN A INTERVENTION:

5c12.During the KAP survey, when mothers were asked if any of their children had a vision problem during the night, 96.2% responded "no". Nightblindness might not be recognized by mothers; however, xerophthalmia is a major public health problem in Nepal. A study in Sarlahi District, demonstrated a 30% reduction of mortality in children aged 6-72 months who received vitamin A capsules (Lancet 1991; 338:67-71).

5c13.Natural sources of Vit A in the area are pumpkin, dark green leafy vegetables, papaya and mustard leaves.

5c14.A MOH protocol for Vit A supplementation is in the process of preparation and will be followed. The number of children for Vit A distribution: O-71 months: 7,738 children. The approximate number of visits will be two per year during Vit A distribution camps. Each VDC will conduct two camps. In Year 1 there will be 1 per VDC (14) and Year 2 (28 camps) and Year 3 (28 camps). The children will be enrolled through **CHVs** at the ward level and invited to the camps.

5c15.The objective is: 40% of children under 60 months will receive vitamin A supplementation every 6 months. The beneficiary population totals 2,500 children. Vitamin A rich foods will be encouraged in nutritional messages through forums mentioned in the above section. Vitamin A rich kitchen gardens are an activity of the Women's groups.

5c16.The Vit A strategy will be to support DPHO in establishing Vitamin A supplementation program. CHVs, **TBAs,** and community participants will be trained on vitamin A requirements of children, appropriate food sources, and the promotion of kitchen gardens.

5c17.The Project Coordinator, Rabindra Thapa, will be responsible for technical oversight of Vit A interventions with a staff nurse in each ilaka responsible for Vit A at the ilaka level (l-Netra, 12-Maya, 13-Bhim)

5c18.DPHO/HP staff(5) and 24 VHWs will receive technical training in vitamin A prevention and treatment. This training will be part of three days of nutrition training given in year 2. 126 **CHVs** will receive one day of training. The VHWs will be responsible for supervising the **CHVs.**

5c19.The MOH card is attached in an Appendix.

GROWTH MONITORING:

5c20.The project will not include a comprehensive growth monitoring intervention. The MOH and CHVs are unable to provide services necessary to make the GM/P intervention effective (i.e., regular weighing and follow-up of high-risks). The project will strengthen the assessment of nutritional status and case management of malnutrition through technical and logistical support provided to the Health Posts.

5c21-27. The project will not conduct growth monitoring activities.

5c28.The MOH Road-to-Health card is used b HP staff (refer to Appen, C). The availability of these cards is inconsistent and only 3.3% oPthe mothers interviewed during the RAP survey have them.

5c29.If through observation a child is losing weight, then the child will be referred to the health post by the **CHV** and the mother will be counselled by both CHV and VHW.

5c30.The link between growth monitoring and nutritional improvement activities is tenuous in this area. The amount of effort and training involved in regularly weighing children displaces too much time and energy from providing nutritional education and counselling. Paying too much attention to the measurements monthly often leaves education/promotion wanting and does not effect nutritional status. Thus, this project will concentrate on providing basic nutritional messages. Geography and educational level of workers greatly limit the success of a growth monitoring activity. Nar Maya, Asst. PH Coordinator will be responsible for nutrition interventions.

SECTION D5d. DIP FOR CARE OF MOTHERS

5dl. The estimated maternal mortality rate for Nepal is **830/100,000** live births (1992 UNICEF).

5d2. Access to ante-natal care is extremely limited. The **KAP** survey revealed that 0% of mothers possessed an antenatal card. Women believe that dark, green leafy vegetables should be avoided post-partum. Focus group discussions will reveal what women understand about appropriate weight gain during pregnancy.

5d3. Most women self-deliver their babies. Few family members help during a delivery. Some cases are handled by untrained TBAs using unsafe practices. Delivery practice is considered "untouchable". Women are also shy to have any attendant while delivering.

5d4. Post-natal care is unavailable and women are usually back working in the fields 15 days post-partum.

5d5. Prolonged breastfeeding is the most commonly utilized method of birth spacing. The contraceptive prevalence observed among women who did not desire pregnancy at the time of the KAP survey was 8.1%. Thus there is an unmet need among 91.9 % of all currently married women as potential users. Women are considered to be in need of family planning, if they are not contracepting, and either want no more births or want to postpone the next birth for two years or more. Only pills are available occasionally. IUD, Depo and condoms are not available which explains why only 8% of total demand is being satisfied.

5d6. The beneficiary population for maternal care interventions is:

15-19 years: 1485	30-34 years: 1181
20-24 years: 1638	35-39 years: 1028
25-29 years: 1409	40-44 years: 914 TOTAL: 7655

The high-risk approach will not be undertaken; rather, all women 15-44 years will be eligible for appropriate antenatal and postnatal services at the HPs and MCH mobile clinics. Community-based communication strategies will improve knowledge and practices regarding antenatal care and cleanliness at time of delivery.

5d7. The maternal care objective is: 40% of mothers will know the three clean birth principles.

5d8. The project will support increased access to improved antenatal services through technical training and logistic support of HP-based and MCH clinics. **CHVs** and TBAs will play a vital role in the community-based communication strategies. Transport for emergency care will not be provided, although the referral system will be strengthened by creating linkages with the local hospitals. Adolescent girls will be prepared in family life education through the school health component of the project (five high schools), through NFE classes/out-of-school program and through mass education programs.

The maternal strategy will focus on safe delivery practices, as 90% deliveries still take place at home, usually under septic conditions. A majority of TBAs do not wash their hands, do not deliver on a clean surface and do not use clean cord cutting tool. SC proposes to test an appropriate, inexpensive, and clean single-use delivery kit through a UNICEF, UNFPA funding. This kit will be promoted during this project.

5d9. Planned inputs/outputs:

*Collaborate with DPHO to provide maternal **health/FP** refresher training to health post staff. *Training for SC Nuwakot team, HP staff/VHWs, CHVs, **TBAs.** *Iron/folate supplementation at MCH clinics. *School health program in 5 high schools: family life education. *Promotion of Safe birth Kits through women's groups, mother's groups and CHVs and **TBAs.** *Facilitate MCH mobile clinics.

Activities by Yr:	**1**	**2**	**3**
Meet with HP staff, **CHVs,TBAs,** mother's groups, comm.leaders	3x	3x	**3x**
Coordination with DPHO	2x	2x	**2x**
Mothers group training(upto days)	**30**	80	126
Sites of MCH clinics	**23**	**28**	28
Number of clinics held	70	**145**	145
MCH management committees formed	14		--
Marketing of Safe Birth Kits	--	4-i	**60**

Expected outcomes: Mothers will be aware of three safe birth practices and eligible couples will be using contraceptives.

5dlO. The MOH does not have a regular supply of mother's cards. The project will use the SC Prenatal card used in other SC project areas (see appendix).

5d11.The numbers/types of workers to be trained in maternal health will be:

* 126 CHVs	: 2 days with 2 day refresher quarterly each year
* 126 TBAs	: 10 days with quarterly refresher each year
* 45VHWs	: 3 days with quarterly refresher each year
* 10 NFE supervisors	: during initial 8 day health training
* 126 Mothers groups	: 2 days with quarterly refresher

The quality of health workers performance will be supervised quarterly by SC staff and VI-IWS.

5d12. The birth spacing objective for the project is: 15% of eligible couples will be using any method of contraception. Birth spacing promotion will be conducted through mother's groups, parenting groups, child care cooperatives, women's savings groups and school health classes. Technical training and logistical support of contraceptive availability will be provided to the VHWs and HP staff. Utilizing CHVs and TBAs as distributors of family planning supplies will be discussed with the MOH.

5d13. Messages will be further refined after focus group discussions. The main messages include: * Healthy mother and child if 4-5 year space * Small families are healthy families * Spacing for economic improvement. Men will receive messages during parenting classes.

5d14. Equipment and supplies to be purchased are: tensimeters, thermometers, stethoscopes, mats, bedsheets, buckets and bags for MCH clinics. Mass media educational materials to be used will be provided through the UNICEF grant along with Safe Birthing Kits for the first year of the project.

5d15. Person responsible for technical oversight of the maternal care and family planning component will be Nar Maya, Deputy PH Coordinator.

SECTION D5e. DIP for Case Management of ARI

5el. It is estimated that an average child during the first five years of life may suffer from 4.8 episodes of ARI per year **(HMG/Nepal** and UNICEF: Situational Analysis of Children and Women 1992). Survey results from Jumla in 1988 (JSI and Nepal Red Cross) indicated that 23% of all childhood deaths were a result of pneumonia alone or in combination with diarrhea. Of these deaths, 70% occurred during the first year of life and 42 % even before the age of three months. In terms of morbidity, nearly 0.9 treatments were necessary for each child under five and infants needed 1.7 treatments, The specific mortality rate is **108/1000** for infants and **42.7/1000** for children l-5 years (Status of Health in Nepal, 1991)

5e2. According to the KAP survey, 43.8% of mothers observed signs of respiratory problems such as cough and difficulty in breathing in their child during the previous 15 days. Of these children, 96.7% observed rapid and difficult breathing. Only 55.4% sought treatment for the illness, consulting with the following: 6% hospital; 3% HP; 3% doctor; 6% medicine shop; 1% VHW; 30% traditional faith healer; 13 % relatives/friends; and 39 % others. In terms of recognition of symptoms 14 % of mothers did not **know,** 18 **%** rapid breathing, 7% abdominal respiration, 8% loss of appetite, 24% fever, 21% cough, and 8% other. Currently, there is not any parental education regarding ARI.

5e3. The MOH protocol for treatment of pneumonia is based on assessment of severity of illness. Cases of mild ARI are characterized by cough, sore throat, nasal congestion and a respiratory rate **> 50/minute.** Supportive treatment includes: Give extra fluids, including breastmilk; keep the child cool, do not overwrap; and Give paracetamol for fever.

Moderate ARI is characterized by all of the above and a respiratory rate >50 per minute. Antibiotics are given as follows: Cotrimoxazole for 5 days according to weight and fortified Procaine Penicillin for 5 days according to weight.

Severe ARI is characterized by all of the above plus chest indrawing and requires referral to the hospital if possible. The child is given one dose of FPP prior to referral. If referral is not available, these cases are given antibiotics and supportive treatment.(Chloramphenical syrup 4 times daily for 7 days; neonates less than one month are given chloramphenical syrup for 7 days but less frequently per day).

Currentl parents do not pay for antibiotics dispensed at the HP, but may need to purchase them x om a medical shop. The MOH does not yet permit VHWs or CHVs as frontline health workers to provide antibiotic treatment.

5e4. Currently, the ARI infrastructure is greatly lagging behind need. Although there are 4 health posts, one-third of mothers bring their children to faith healers as HP are often not staffed and do not have antibiotic supplies.

5e5. The percent of all ARI episodes in under-five children that were possibly treated with antibiotics would at the most be 18% if those consulted actually prescribed medication. The cost is approximately US$ 1.88 (85 rupees) per course of cotrimoxazole.

5e6. The targeted beneficiaries are:

Children 0- 11 months: 1,340
Children 12-23 months: 1,288
Children 24-59 months: 3,467

Local barriers to children receiving appropriate diagnosis and treatment are lack of recognition of ARI, lack of trained and active health personnel, lack of antibiotic supply and distance to health facilities in the area. Traditional practices limit women's mobility which has a negative effect on prompt care-seeking behavior as is lack of cash to purchase medicines. The rainy season poses a barrier for seeking care due to the muddy trails.

5e7. The objective for ARI is: 25% of families will be competent at early detection of ARI and referral of cases to health posts for treatment.

5e8. The planned ARI component is to work with DPHO to establish appropriate referral services through development of treatment protocol and supply system for antibiotics. Provision of ARI training to health post staff, CHVs, **TBAs,** literacy classes, and ECE program participants in recognition and appropriate treatment of ARI will be the major input.

SC would like to pilot a case study by determining if ARI morbidity and mortality is reduced if VHWs are permitted to provide antibiotics. This would be a small area study whereby a case-control to another area within the project is observed. Approval by MOH officials in Kathmandu and at the District will be needed.

5e9. The project will train and support existing health staff and facilities to improve diagnosis and treatment of ARI cases. SC would also like to train a new type of worker not yet trained in early detection and treatment, namely the VHWs in 3-4 wards only.

5e10.Relationships to the local Health Posts are necessary with linkages within MOH at the national level as well, Antibiotics will not be provided by this project, although supply routes will be studied and encouraged.

5e11. Given the nature of ARI, its quick progression, and the existing health infrastructure which cannot meet the needs of the rural communities, front line workers must be trained to deal with this. Estimated travel time to the nearest referral site is 4 hours. The case management of ARI requires closer attention by workers closer to the families. SC will test and advocate for training of CHVs and VHWs in early detection, diagnosis and case management of ARI.

5e12. Five DPHO/HP staff and 14 VHWs will receive technical training of one day duration. The training will focus on treatment and referral. This training will be given concurrently with 2 months of clinical supervision of HP staff. The Project Coordinator and staff nurses will supervise the quality of performance in ARI case management. 126 CHVs will receive one day of training on the earl detection and treatment of ARI, emphasizing prompt referral. VHWs will assess the peRormance of CHVs. Following the development of appropriate messages regarding ARI detection and referral a series of communication skills trainings will be given. NFE advanced classes provide education and skills in smokeless chulos (stoves).

5e13. The project will support current MOH policy regarding case management of ARI, including distribution of antibiotics. Investigation of community-based distribution of antibiotics may be considered in the final year.

5e14. Training materials in ARI will be developed if a search of available materials does not elicit appropriate materials.

5e15. Supervision of ARI case management by HP staff will be conducted by SC project coordinator and staff nurses and VHWs assisted by SC project staff. Morbidity will be assessed through HP records. MCH clinic records will be reviewed. Reviews of antibiotic utilization will be conducted and a sample household survey held at midterm. A study will be designed to determine the difference between having VHW's responsible for improved case management.

5e16. Specific messages will be developed after focus group discussions are held in the area. Promotional materials and methods will be developed as appropriate to the communication strategy.

5e17. Project staff will work with the DPHO to improve the availability of antibiotics. If an adequate supply cannot be maintained SC will consider purchasing antibiotics with private funds.

5e18. Technical oversight of the ARI component will be: Rabindra Thapa, Project Coordinator.

SECTION D5f. DIP for FEMALE LITERACY

5fl. The CS 8 KAP survey documents a female illiteracy rate of 93.4% and 95.7% among mothers. Given the known relationship between female literacy and health knowledge and practices at the household level this CS 8 project includes literacy training for women as a child survival intervention. It is expected that CHVs, TBAs and mothers' group members will become stronger,. more knowledgeable advocates for child and maternal health through attainment of basic literacy skills and training in communication of child survival messages. Current infrastructure in the area to provide adult literacy classes is lacking.

Literacy classes have proven to be an effective mechanism for increasing the KAP of women in diarrhea management, immunization, nutrition, population issues and family

planning (Impact of the SC/US Nonformal Adult Education Program on Mother and Child Health Care, Lok Raj Bhatta, 1991.). Women completing the advanced literacy classes have formed successful savings accounts and revolving funds.

5f2. By the end of the project, female literacy rate will increase to 30% of 15-45 year population. The estimated number of beneficiaries will be: 3,520 women mostly of 15-45 years, 900 illiterate men, and 1,720 children aged 8-14 years. The estimated number of students during the life of the grant will reach over 6,140.

5f3. Students will be enrolled in a variety of classes dependent upon age, geographic location, and previous enrollment in schools:

Basic Literacy Classes: NFE centers are established in communities where 20-25 adult female students request literacy training. These evening classes are held six days per week and are facilitated by a local literate resident. The nationally standardized MOE curriculum is completed in six months.

Advanced Literacy Classes: These classes are comprised of graduates of the basic class. They are conducted in the evening at community NFE centers, facilitated by a local resident. The curriculum developed by SC in Gorhka will be used. This curriculum focuses on health issues such as diarrhea prevention and treatment, immunization and child spacing. AIDs/STD awareness will be added. The SC curriculum is being used by over 12 INGOs, 2 NGOs and 1 GO presently.

Out-of-school classes are held in the morning for children who do not attend school (aged 8-14 years)

The following number of classes/students are scheduled:

Type of class	Yr1	Yr2	Yr3
Basic Literacy	104/2080	7511400	60/1100
Advanced literacy	---	80/1600	50/ 980
Out-of-school children	---	50/1000	251500

By Topic (# of students knowledgeable in following areas)*

			600
ORT (able to use)	--	500 150	200
STD/AIDS	---	400	490
Sanitation	135	---	140

*(Passed competence test)

5f4. Inputs include:

*Collaborate with DE0 to increase women's literacy to promote leadership skills and MCH/CS protective behaviors. *Conduct 239 6mo. basic literacy classes for CHVs, TBAs, and other women (25 students/class) followed by 130 6 mo. advanced literacy classes for graduates (20 students/class) with emphasis on EPI, ORT, MCH (including AIDS), and nutrition messages. * Form 40 women's groups from advanced classes with focus on savings/revolving funds and advanced CS messages. * Conduct 75 out-of-school children classes of 9 months duration (25 students/class) with emphasis on health.

5f5. Udhaya Manandhar, Program Officer - Education is responsible for technical oversight of the literacy program and in Nuwakot: Ilaka 1: Rajendra Lama, 12: Bed Lama, 13: Jay Shrestha. Field supervision is provided by a team of 10 NFE supervisors, who receive 7 days of training on NFE supervision. They observe lo-12 classes at least twice per month. The 313 NFE facilitators receive 15 days of literacy program training. Literacy classes will be used as a venue for dissemination of child survival messages. NFE supervisors and facilitators will receive communication skills training regarding the targeted child survival messages, enabling them to effectively share these messages with their class participants.

5f6. CSVIII grant monies are allocated for 100% of the NFE Coordinators salary, materials and supplies for the basic literacy classes and salaries of the NFE program supervisors. Support for literacy books will be from UNICEF for year 1.

DIP for STD/AIDS AWARENESS

5gl. According to a KAP survey conducted during the KAP baseline survey, 210 males and 210 females aged 15-45 years were interviewed. General awareness of STDs is very low (15 %), with 7% among females and 8% among Tamangs. Among illiterates, 4 % are aware of STDs, while STD awareness is 69% for people with 6-10 class level of education. Only 9% know about the prevention of STDs and 13% have knowledge of signs and symptoms of STDs. More respondents know about AIDS (24%); for females 13%, and 15 % for Tamangs.

Nuwakot District is known as a source of women for trafficking, especially from the project area. Already, a fatal case of AIDS has been reported, as have cases of HIV seropositivity. Identification of these cases has resulted in growing concern regarding STDs, including HIV infection, in an area closely connected to Kathmandu.

Due to the problem of woman trafficking and prostitution from Nuwakot district to India and other parts of Nepal, SC will address the problem of STDs and AIDS through increasing awareness and prevention and conducting STD camps. A one year grant from WHO GPA will complement the efforts of the CS VIII intervention, working with two local NGOs and the government.

5g2. Estimated size of beneficiaries is 16,000 men and women between 15 and 45 years of age. "High-risk" is defined as the entire reproductive age group, especially non-condom users, prostitutes and prostitute returnees.

5g3. The objective is: 50% of men and women will be knowledgeable about three main modes of AIDS/HIV transmission and three protective behaviors.

5g4. The strategy will be to collaborate with National AIDS Prevention and Control Program, DPHO, and local NGOs to promote awareness and prevention of AIDS/HIV infection and to train program participants using SC AIDS curriculum as appropriate. STD camps will be held once a year in each ilaka. The first year will be funded through the WHO grant; year 2 and 3 will be funded under CS8.

5g5. Number of workers to be trained:

20 SC staff, 5 HP staff, 126 CHVs, 126 TBAs, 10 NFE supervisors, 313 NFE facilitators, 114 women's group leaders, 20 school teachers, 80% of two NGOs staff and 50 peer counsellors.

5g6. Equipment needed for STD camps and education includes: IEC materials, lab materials(coordinated with Central level NACP), condoms(free from MOH), STD medications

(SC private funds) and training materials.

5g7. Name of person responsible for this intervention is Nar Maya, Deputy Public Health Coordinator.

DIP **FOR** ECE: EARLY CHILDHOOD EDUCATION

5hl. Up-to-date estimates of the problem as documented in the baseline KAP survey show that 42 % of mothers of under-twos leave their children at home during the day and 40 % leave them in a cradle. Chief caregivers during the **morning** and evening are: 42 % mothers, 25 % siblings and 29% grandparents. Twenty-four percent of mothers do not provide any play materials for their children. There is little stimulation verbally or physically. Bathing is done twice a month with oil massage done only for newborns. Usually 15 days after delivery, mothers return to work in the fields. Families have little knowledge of child development. Preschool education is a rarity. The need for an environment which can facilitate the psycho-social development of young children has not been fully recognized.

5h2. This intervention's approach will be to encourage **early** childhood development and raise awareness among the target population. Parenting education classes will be conducted (separate classes for fathers and mothers), child-to-child classes will teach children to teach each others especially given the responsibility of older siblings to the rearing of children. **A** child care cooperative will be formed whereby women share day care responsibilities and learn ECE techniques.

5h3. Beneficiaries for this intervention include:

children under three years of age:	3,968
children 8-14 years of age:	180
parents:	840

5h4. The projected activities are:

(18 Home Based Child Care Center : 7 child/mother:	168
7 Helper committee (pressure group) for Child Care Center:	126
6 Child-to-child classes from out of school program:	240
39 Parenting education (20 men/20 women per class):	975
40 Women's groups (Savings group):	420

GROUP **formation:**	**Yrl**	**Yr2**	**Yr3**	Total
Fathers group parenting	181360	**21/420**	ongoing	39
Mothers group parenting	181360	2 l/420	ongoing	39
Child Care Coops	**6/84**	121168	ongoing	18
Child-to-child groups	**3/60**	**6/60**	ongoing	9
NFE Women's groups	181360	211420	ongoing	39
Self-help groups	**3/60**	**3/60**	ongoing	6

5h5. Inputs include: Collaboration with DE0 to establish experimental ECE program linked to EPI and nutrition. Provide ECE training to SC, DE0 and DPHO staff, parenting class facilitators, CCC participants, and child-to-child program leaders. Establish 18 home-based child care cooperatives to provide sustainable day care for children (5-7 children per caretaker). Organize 39 parenting classes (fathers and mothers groups of **20-30/class)** and 18 child-to-child groups. Train all groups in benefits of EPI, MCH, breastfeeding, use of weaning foods and supplementary foods, and growth monitoring.

5h6. IEC materials will be needed as well as 18 ECE kits, 3 models for parenting classes and 3 tool boxes for toy making.

5h7. The person responsible for technical oversight of all ECE activities is Sashi Rijal, Program Officer - Productivity.

SECTION E: HEALTH INFORMATION SYSTEM

E.1 Human resources responsible for the HIS include the Public Health Coordinator in Kathmandu, Chanda Rai, for overall management of the HIS, and for field supervision, the Project Coordinator, Rabindra Thapa. Raghu Thapalia, the Kathmandu-based Monitoring Officer will provide technical assistance with monitoring and evaluation along with Navin Pyakurel, Health Research and Training Officer, a demographer.

The project proposes to spend $22,816 on expenses related to baseline survey and midterm and final evaluation. A computer and computer supplies is also budgeted at $4,000 to support the management information systems of the project. This totals 5 % of the budget.

The materials for HIS include notebooks and rosters as well as survey questionnaires. Technical assistance from Westport will be available if necessary to help develop the HIS which should be operationalized in June 1993. Consultancies for evaluation/survey activities will be provided by the Headquarters Health and Education Units. In addition, funds have been budgeted for SC's Regional Health Program Advisor. Local Nepali consultancy firms will be hired when appropriate.

E2. A complete census will not be conducted; however a 30-cluster sample survey was done in November 1992 and is attached.

E3. Given MOH's commitment to establish a nationally standardized HIS, the CS 8 project will adopt the forms and procedures developed by MOH and strengthen its utilization. Quantitative data will be collected from the MCH mobile clinics service delivery records through the VHWs to the SC field coordinators on a monthly basis. The NFE facilitators, NPE supervisors, VHWs and CHVs will collect data. Health Post and DE0 staff with SC assistance will compile the data and analyze it. The PH Coordinator will be responsible for overall functioning of the system. Indicators include: EPI coverage by antigen, Vit A coverage, ARI cases and referrals, antenatal check-ups, and contraceptive prevalence. Birth and death reporting will be supported through the HP and checked quarterly as will the HP morbidity statistics. Qualitative indicators will include checklists by supervisors as to expected performance and through observation and spot-checking mothers' knowledge. Mini surveys will be conducted to measure RAP changes. Cross checking of data from the MCH clinics will be done bimonthly by the field coordinators using the HP rosters. Qualitative data will be collected quarterly through the management committee meetings.

A system for maintaining the confidentiality of personal health data will be devised by Marsha Dupar, a clinical nurse/midwife. Data will be stored in the field and sent to Kathmandu office to be tabulated. Staff will be given feedback of their activities on a quarterly basis. Community meetings will be held quarterly as will DPHO meetings. PVO home office and USAID will receive quarterly and annual reports. At the time of the midterm and final evaluations a KAP survey will be conducted.

E4. The Project Coordinator and Public Health Coordinator have both received extensive training in HIS from Westport (HIS Workshop). The PC also attended the India KAP survey training. Raghu Thapalia, Monitoring Officer and Navin Pyakurel, Health Research & Training Officer, attended a SC monitoring and evaluation workshop in Bhutan in January

1993.

E5. The MOH was not directly involved in the KAP survey. Thirty-three interviewers were hired from the community. Twelve supervisors, 2 coordinators, and 2 training coordinators were provided by SC staff. Two hundred and ten mothers of under-twos were interviewed for the basic KAP survey and 210 males and 210 females aged 15-45 for the AIDS/STD survey. Data collection took 7 days. The survey cost US $1,666.

SECTION F: HUMAN RESOURCES

F1. Please see Appendix for biodata of key staff. The Kathmandu organizational chart is also included in the appendices.

All positions are full-time, salaried, and filled by host country nationals except the Director who is expatriate.

Public Health Coordinator: Supervises and manages all SC field health personnel with responsibility for technical content of training and services.

Deputy Public Health Coordinator: Assists with supervision and training in field.

Project Coordinator: Based in Nuwakot to manage overall CS8 project and provide liaison directly with DPHO and DEO.

Staff Nurse: Trains DPHO staff, VHWs, CHVs, TBAs and Women's Groups; supervises MOH clinics.

ANM/CMA: Coordinates MOH mobile health clinics and trams VHWs, CHVs and Women's Groups.

NFE Coordinators: Trams literacy facilitators, supervisors, ECE home-based childcare workers, and parenting class facilitators.

NFE Supervisors: Supervises and manages literacy and parenting classes, out-of-school children classes, and child-to-child classes; at least 2-3 per ilaka.

Women Development Coordinator: Trams women group leaders and manages establishment of group revolving funds.

IEC Coordinator: based in Nuwakot will be hired to provide the IEC technical oversight. Planned activities include: focus group interviews to investigate health KAPs; identification of relevant messages; identification of IEC materials prepared by other agencies; development and field-testing of IEC methods and materials, and implementation and evaluation of IEC activities.

Administrative and financial management support will be provided by the existing Kathmandu SC office personnel. SC HQ Health (Director/Health Unit Manager) and Education (Director/Ed Specialist) Units will provide regular technical (CS, ECE, NPE) and admin support. Regional Health Advisor will provide annual TA.

F2. The total number of community groups formed will be found in section 5h4. An additional 126 Mother's Groups will be formed which totals 276 groups. Groups meet at least monthly.

F-3. The project will work within the following MOH structure:

126 TBAs: 45 female volunteers trained by the Nursing Division four years ago. An additional 81 (1 per ward) to be trained.

126 CHVs: Female volunteers from the community work part-time motivating families on a household level. Many are non-literate.

24 VHWs : Lowest level paid MOH male workers who supervise CHVs, conduct EPI clinics, and collect information at the household level.

Health Post staff: Health Post In-charge supervises the 6 VHWs, 2 Community Medical Assistants (CMA) and 2 ANMs from each Health Post.

F4. Total number of health workers:

	RATIOS
126 CHVs volunteers	1/055 families
126 TBAs volunteers	1/055 families
14 VHWS	l/500 families
8 HP Supervisors	l/O33 health worker
27 SC supervisors	l/O10 health worker

F4. The proportion of previously trained CHVs who are active is estimated to be 50 % . Much of this attrition is due to the lack of a proposed monthly wage by MOH.

F5. Training and quarterly meetings along with supervision are tremendous incentives for CHVs. Other incentives including certificates and uniforms will be determined by the community themselves.

F6. Technical skills training will be held for key staff in program planning, budgeting and reporting. Conferences and workshops in relevant areas will be attended. The PH Coordinator will attend a AIDS/STD Conference in Berlin in June 1993 and Program Officer-Women Development is attending an ECE Workshop in Singapore in Feb. 1993.

F7. This project does not have an expatriate staff. The Project Coordinator in Nuwakot is a national as is the Public Health Coordinator in Kathmandu. Computer skills training and further skills in project planning and budgeting will be provided.

F8. SC/Headquarters backstopping will be provided by Dr. Ahmed Zayan. Dr. Katherine Kaye will provide technical support and Donna Sillan in the Asia/Pacific region will provide consultancies as requested. Laurine Brown will provide TA in Vit A, conducting a follow-up workshop in June 1993. Donna Sillan visited in January 1993 to assist in the DIP.

SECTION G: MANAGEMENT AND LOGISTICS

G1. All transport in the impact area is by foot; however, it is a 5 hour drive by car to the start of the walking path to the project area.

62. Supplies and materials to be obtained: 3 cassette recorders, 1 slide projector, 3 solar panels, furniture and bedding, 130 TBA kits, 18 early education kits, 3 toy box tools, 3 models for parenting classes, costumes for street drama, HIS supplies, medical equipment for MCH clinic, cold chain equipment, condoms, hand microphone, 5 metrolamps, kitchen utensils, ORT comer utensils, training supplies.

TABLE B: COUNTRY PROJECT SCHEDULE OF ACTIVITIES

(Check box to specify Quarter and Year)

PVO: Save the Children
Country: Nepal

	Year 1				Year 2				Year 3			
	1	2	3	1	4 1	2	3	4	1	2	3	4
1. Personnel in Position												
a. Public Health Coordinator	x	x	x	X	X	X	X	X	X	X	X	X
b. Dy. Public Health Coordinator	x	x	x	X	X	X	X	X	X	X	X	X
c. Field Coordinator/Wormen Dev. Coord.	x	x	x	X	X	X	X	X	X	X	X	X
d. Staff Nurse/ANM/CMA/Accountant/ NFE Coordinator	x	x	x	X	X	X	X	X	X	X	X	X
e. IEC Coordinator/CMA (1)		X	X	X	X	X	X	X	X	X	X	X
2. Health Information System												
a. Baseline Survey	X											
– Design/preparation	X											
– Data collection and analysis	X											
– Dissemination and feedback to community and project management		X	X					X				X
b. Consultants/Contract to design HIS												
c. Develop and test HIS												
– Implementation												
– Development and feedback to community and project management												
3. Training												
a. Design	X	X										
b. Training of trainers	X		X					X				
c. Training sessions	X	X	X	X	X	X	X	X	X	X	X	X
d. Evaluation of knowledge and skills		X	X	X	X	X	X	X	X	X	X	X
4. Procurement of Supplies												
5. Service Delivery to be initiated												
a. Area 1:												
– Control of Diarrheal Diseases			X	X	X	X	X	X	X	X	X	X
– Immunization			X	X	X	X	X	X	X	X	X	X
– Nutrition												
Breastfeeding												
Maternal Nutrition												
Vitamin A				X	X	X	X	X	X	X	X	X
Growth Monitoring/Promotion												
– Control of Pneumonia			X	X	X	X	X	X	X	X	X	X
– Family Planning/Maternal Care			X	X	X	X	X	X	X	X	X	X
– Other:												
b. Area 2:												
– Control of Diarrheal Diseases												
– Immunization												
– Nutrition												
Breastfeeding												
Maternal Nutrition												
Vitamin A												
Growth Monitoring/Promotion												
- Control of Pneumonia												
- Family Planning/Maternal Care												
- Other:												
6. Technical Assistance												
a. HQ/HO/Regional office visits		X				X						X
b. Local Consultants			X				X				X	
c. External technical assistance						X						X
7. Progress report												
a. Annual project reviews				X				X				X
b. Annual reports					X				X			X
c. Mid–term evaluation												
d. Final evaluation								X				X

DIP TABLE C: ESTIMATED COUNTRY PROJECT BUDGET

BUDGET (Field + HQ) | **Place dollar amounts in shaded areas only** |

PVO/COUNTRY: Save the Children Nepal	Year 1 (a) A.I.D.	Year 1 (b) PVO	Year 2 (c) A.I.D.	Year 2 (d) PVO	Year 3 (e) A.I.D.	Year 3 (f) PVO	TOTAL - Years I-3 (g) A.I.D.	TOTAL - Years I-3 (h) PVO	TOTAL - Years I-3 (i) TOTAL
. PROCUREMENT									
A. Office Equipment (< $500)									
1. Office	5,931	32,500	1,500	0	0	0	7,431	32,500	39,931
2. EPI	0	0	0	0	0	0	0	0	0
3. ORT	0	0	0	0	0	0	0	0	0
4. Other	0	0	0	0	0	0	0	0	0
SUBTOTAL	5,931	32,500	1,500	0	0	0	7,431	32,500	39,931
B. Supplies									
1. Office	0	4,000	0	4,500	0	5,000	0	13,500	13,500
2. EPI	0	500	0	500	0	500	0	1,500	1,500
3. ORT	0	500	0	500	0	500	0	1,500	1,506
4. Other	16,885	5,177	19,253	6,972	13,998	4,590	50,136	16,739	66,875
SUBTOTAL	16,885	10,177	19,253	12,472	13.998	10,590	50,138	33,239	83,375
C. Consultants (exclude evaluation costs)									
1. Local	1,000	1,000	1,000	1,000	1,000	1,000	3,000	3,000	6,000
2. External	5,000	0	3,000	0	5,500	0	13,500	0	13,500
SUBTOTAL	6,000	1,000	4,000	1,000	6,500	1,000	16,500	3,000	19,500
D. Services (exclude evaluation costs)									
1. Manpower Services	0	0	0	0	0	0	0	0	0
2. Lectures/Talent Fees	0	0	0	0	0	0	0	0	0
3. General Contractual Services	0	0	0	0	0	0	0	0	0
SUBTOTAL	0		0		0	n		0	
PROCUREMENT SUBTOTAL	28,818	43,677	24,753	13,472	20,498	11,590	74,867	68,739	142,806

DIP TABLE C: ESTIMATED COUNTRY PROJECT BUDGET

BUDGET (Field + HQ)

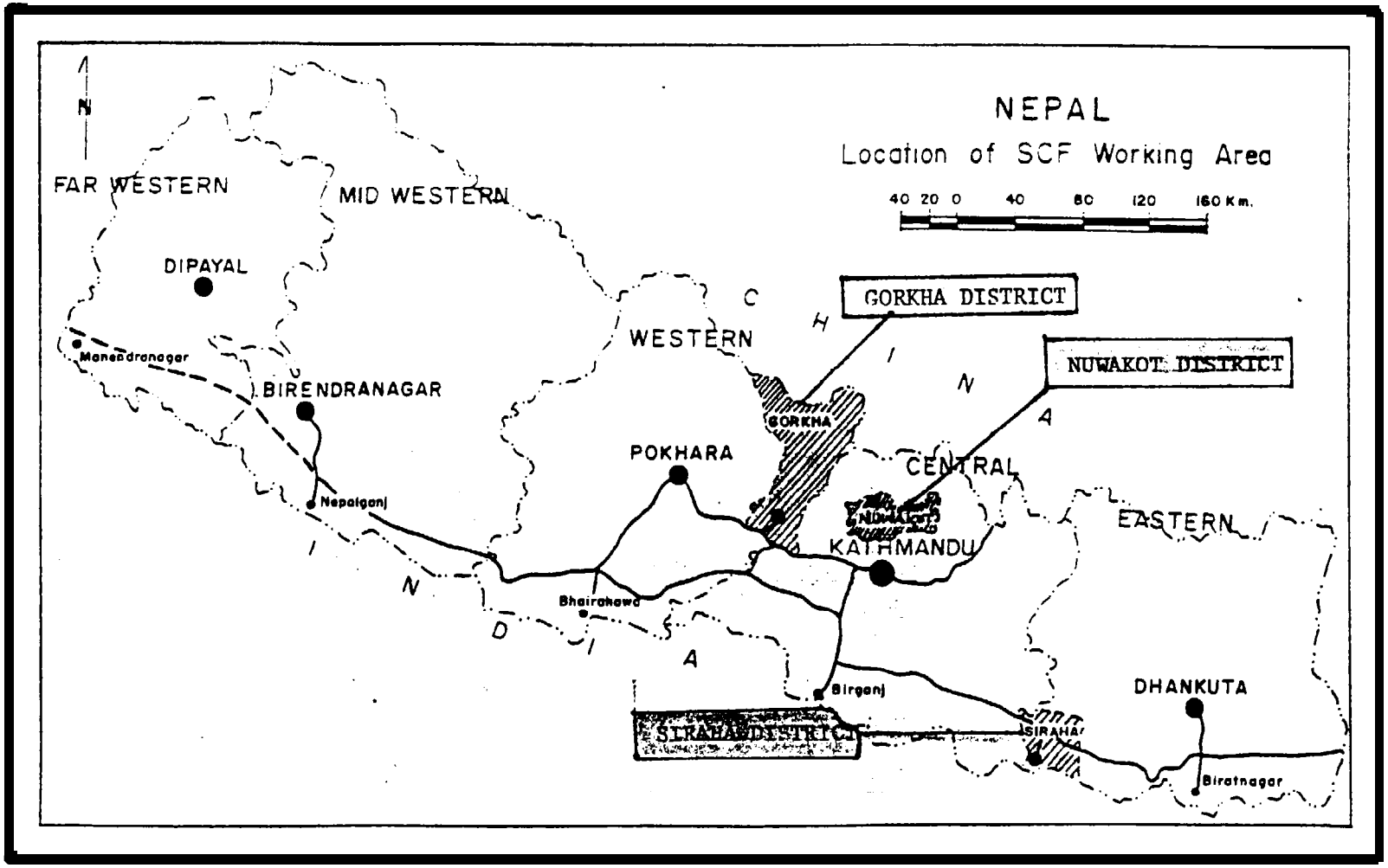
Place dollar amounts in shaded areas only

PVO/COUNTRY: Save the Children	Year 1 (a)	(b)	Year 2 (c)	(d)	Year 3 (e)	(f)	TOTAL - Years I-3 (g)	(h)	(i)
Nepal	A.I.D.	PVO	A.I.D.	PVO	A.I.D.	PVO	A.I.D.	PVO	TOTAL
II. EVALUATION (specify)									
A. Baseline Survey									
1. Consultant/Contract	0	0	0	0	0	0	0	0	0
2. Staff Support	300	0	0	0	0	0	300	0	300
3. Other	1,366	0	0	0	0	0	1,366	0	1,366
SUBTOTAL	1,666	0	0	0	0	0	1,666	0	1,666
B. Mid-term									
1. Consultant/Contract	0	0	5,000	0	0	0	5,000	0	5,000
2. Staff Support	0	0	785	0	0	0	785	0	785
3. Other	0	0	4,000	1,000	0	0	4,000	1,000	5,000
SUBTOTAL	0	0	9,705	1,000	0	0	9,785	1,666	10,785
C. Final Evaluation									
1. Consultant/Contract	0	0	0	0	3,500	1,000	3,500	1,000	4,500
2. Staff Support	0	0	0	0	865	0	865	0	865
3. Other	0	0	0	0	4,000	1,000	4,000	1,000	5,000
SUBTOTAL	0	0	0	0	8,365	2,000	8,365	2,000	10,365
EVALUATION SUBTOTAL	1,666	0	9,785	1,000	8,365	2,000	19,816	3,000	22,616
III. PERSONNEL									
A. Technical	25.516	6,467	27,559	6,920	29,706	7,404	82,781	20,791	103,572
B. Admit-&ration	8,130	7,021	8,842	7,396	9,623	7,793	26,595	22,210	48,805
C. Clerical	7,700	0	6,357	0	9,111	0	25,166	0	25,168
D. Temporary	3,100	0	2,300	0	2,300	0	7,700	0	7,700
PERSONNEL SUBTOTAL	44,446	13,468	47,058	14,316	50,740	15,197	142,244	43,001	105,245

DIP TABLE C: ESTIMATED COUNTRY PROJECT BUDGET

BUDGET (Field + HQ) Place dollar amounts in shaded areas only

PVO/COUNTRY: Save the Children Nepal	Year 1 (a) A.I.D.	Year 1 (b) PVO	Year 2 (c) A.I.D.	Year 2 (d) PVO	Year 3 (e) A.I.D.	Year 3 (f) PVO	TOTAL - Years I-3 (g) A.I.D.	TOTAL - Years I-3 (h) PVO	(i) TOTAL
IV. TRAVEL/PER DIEM									
A. Domestic	8,000	1,500	7,500	1,570	3,000	2,000	18,500	5,070	23,570
B. International	9,091	500	6,000	500	5,500	1,000	20,591	2,000	22,591
TRAVEL/PER DIEM SUBTOTAL	17,091	2,000	13,500	2,070	8,500	3,000	39,091	7,070	46.161
V. COMMUNICATIONS									
A. Printing/Reproduction	5,672	0	1,560	1,000	1,500	1,000	6,732	2,000	10,732
B. Postage/Delivery system	1,500	250	1,550	250	1,600	250	4,650	750	5,400
C. Telephone	1,500	500	1,550	500	1,600	500	4,650	1,500	6,150
D. FAX/Telex	1,500	500	1,550	500	1,600	500	4,650	1,500	6,150
COMMUNICATIONS SUBTOTAL	10,172	1,250	6,210	2,250	6,300	2,250	22,682	5,750	28,432
VI. FACILITIES									
A. Equipment Rentals	0	0	0	0	0	0	0	0	0
B. Facilities Rentals	2,200	0	2,400	0	2,700	0	7,300	0	7,300
C. Other	500	0	500	0	500	0	1,500	0	1,500
FACILITIES SUBTOTAL	2,700	0	2,900	0	3,200	0	8,800	0	8,800
VII. OTHER DIRECT COSTS									
A. Other Direct Costs	8,299	3,000	14,779	3,465	12,907	3,392	35,985	9,857	45,842
OTHER DIRECT COSTS SUBTOTAL	8,299	3,000	14,779	3,465	12,907	3,392	35,985	9,857	45,842
VIII. INDIRECT COSTS									
A. Overhead/Administration	22,977	0	24,154	0	22,433	0	69,564	0	69,564
B. Other	0								
INDIRECT COSTS SUBTOTAL	22,977	0	24,154	0	22,433	0	69,564	0	69,564
TOTAL PROJECT COST	136,166	63,415	143,139	36,573	132,943	37,429	412,248	137,417	549,685


N
NEPAL
Location of SCF Working Area
40 20 0 40 80 120 160 Km.
FAR WESTERN
MID WESTERN
DIPAYAL
Mahendranagar
BIRENDRANAGAR
Nepalganj
WESTERN
POKHARA
Bhairahawa
GORKHA DISTRICT
NUWAKOT DISTRICT
GORKHA
CENTRAL
KATHMANDU
EASTERN
Birganj
SIRAHA DISTRICT
SIRAHA
DHANKUTA
Biratnagar
C H I N A
I N D I A

Appendix A

Appendix B

MOH
EPI
RECORD

खोप को फाइदाहरु

* डी.पी.टी: बच्चाको ३ महिना देखि ११ महिनाको बीचमा ३ पटक सुई लिएमा भयानक रोग लाग्ने खोकीर धनुष्टङ्कारबाट बचाउन सकिन्छ।
▲ पोलियो: डी.पी.टी. जस्तै यो पनि ३ मात्रा खुवाए पछि पक्षघातबाट बचाउन सकिन्छ।
■ बी.सी.जी: एउटै सुईले टी.बी. बाट बचाउँछ।
♦ दादुरा: ८ देखि ३५ महिना भित्रमा एक सुई दिएमा बच्चालाई दादुराबाट बचाउन सकिन्छ।
● टी.टी: १५ देखि ४४ वर्षका महिलाले २ सुई लिने
१. गर्भवती भएको वर्ष आफूलाई
२ बच्चालाई धनुष्टङ्कारबाट जोगाउन
१ पटक सुई फेरि लिने।

आफ्नो बच्चालाई खोपाउनुहोस्

श्री ५ को सरकार
स्वास्थ्य मन्त्रालय
विस्तारित खोप आयोजना

खोपको प्रमाण-पत्र

अर्को खोप लगाउने बेला यो कार्ड लिएर आउनुस्

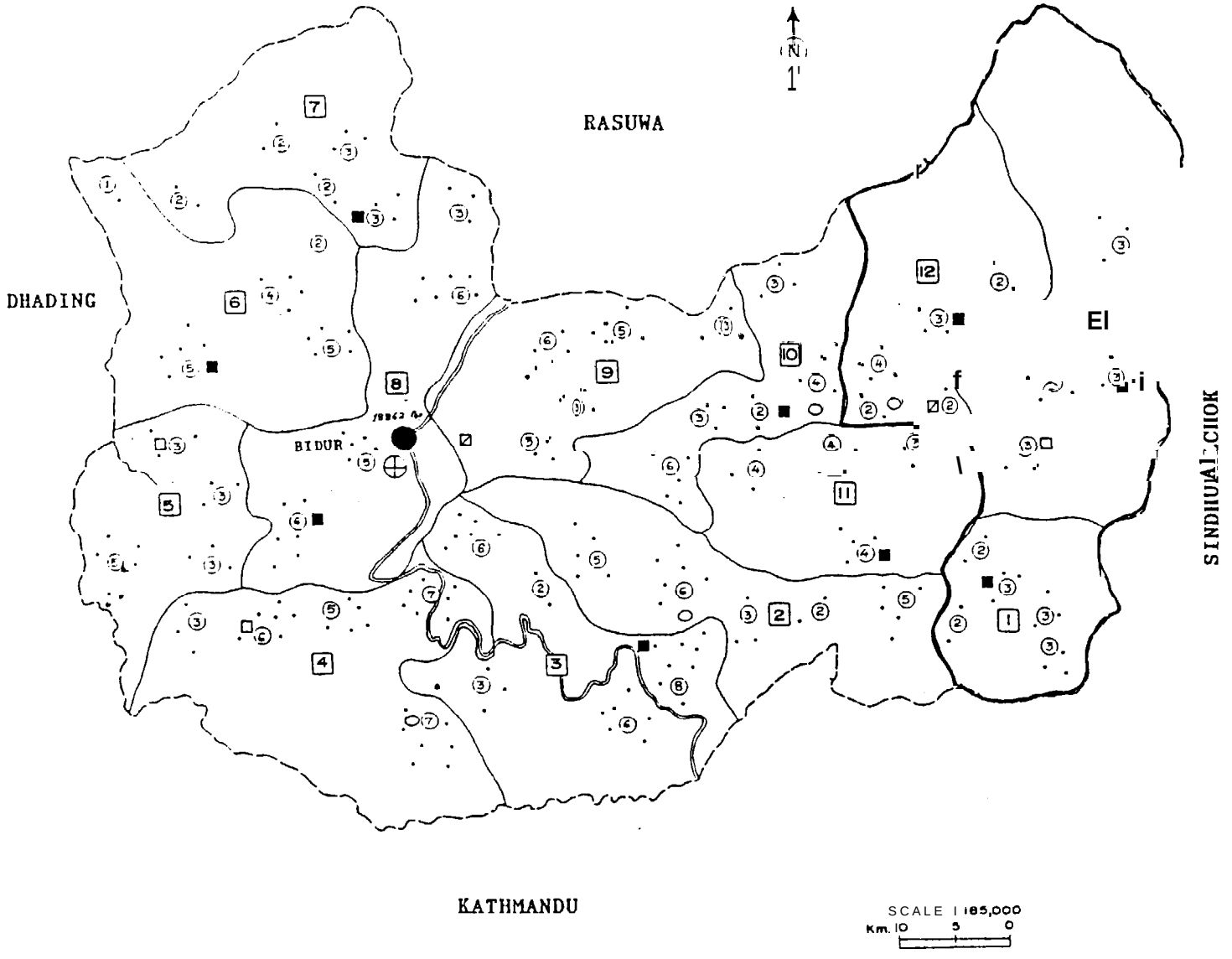
(१)----------	(३)----------
(२)----------	(४)----------

यो कार्ड नहराउनु होला ।

Appendix B

DISTRICT. NUWAKOT

ZONE. BAGMATI



LEGEND	
1	INTERNATIONAL BOUNDARY
2	ZONAL BOUNDARY
3	DISTRICT BOUNDARY
4	ALL WEATHER ROAD
5	SEASONAL ROAD
6	TRACK
7	MUNICIPALITY
8	ILAKA No (Figure inside ilaka number)
9	VILLAGE DEVELOPMENT COMMITTEE (VDC) (Figure inside indicates population)
10	1991, POPULATION (1 dot=1000 persons)

HEALTH INSTITUTIONS	
1	HOSPITAL (H.M.G.)
2	HOSPITAL (Private)
3	HEALTH CENTER
4	PRIMARY HEALTH CARECENTER
5	NGO CLINICS
6	HEALTH POST (Ilaka)
7	HEALTH POST (STATIC)
8	SUB-HEALTH POST
9	AYURVED AUSHADHALAYA
10	Food Asst. Health Inst.. (WFP)

Ilaka	Health Post	DC/M	opulation
	Salle Maidan	5	12,811
	—	5	21,474
	Ranipauwa	5	24,433
	Doipiple (sub)	5	27,486
	Dansing (sub)	4	14,374
6.	Shameri	5	16,825
7.	Kahule	5	12,020
a.	Khadak Bhajyang	4+1	36,474
9.	Nuwakot (static)	5	20,618
10	Khairanitar	5	18,574
11.	Bhadratar	4	13,269
12.	Shikharbesi Samudratar (static)	5	13,312
13.	Rautabesi Betini (sub)	4	11,975
	TOTAL	61+1	245,645

छोराछोरीको संख्या _____

छोरा _____ छोरी _____

मरेको बच्चाको संख्या : _____

पछिल्लो बच्चा जन्मेको मिति: _____

निम्न संकेत र लक्षणहरूको लागी विशेष स्याहार चाहिन्छ र अस्पतालमा गई सुत्केरी हुन सल्लाह दिईन्छ

आमाको बारेमा :-

१-पहिलो जाँचमा घरै अल्परक्तता (Anemic)	थियो ☐	थिएन ☐
२-पोस्ट पार्टम (Post-Partum) रगत बगेको	थियो ☐	थिएन ☐
३-बच्चा जन्माउन गाह्रो भएको	थियो ☐	थिएन ☐
४-सुनिएको र उच्च रक्तचाप	थियो ☐	थिएन ☐
५-क्षयरोग (T.B.)	थियो ☐	थिएन ☐
६-मधुमेह (Diabetes)	थियो ☐	थिएन ☐
७-रक्तदान लिएको	थियो ☐	थिएन ☐
८-मरेको बच्चा जन्मेको	थियो ☐	थिएन ☐
९-अपरेशन	थियो ☐	थिएन ☐

परिवारको बारेमा :-

क्षयरोग	छैन ☐	छ ☐
रक्तचाप	छैन ☐	छ ☐
मधुमेह	छैन ☐	छ ☐
धुम्रपान	छैन ☐	छ ☐
अन्य जण्डिस	छैन ☐	छ ☐

03 24 93 09:08 AM P05

टि. टि. सुई लगाएको

दिएको मिति:

ध्यान दिनुहोस्

१. गर्भ रहेको र दूध खुवाउने आमाले राम्रोसंग पकाएको गेडा-गुढी, दाल र हरियो सागपात खानु पर्दछ ।

२. हुनसक्छ भने त्यस्ता महिलालाहरूले दूध, फुल र मासु पनि बढी खानु पर्दछ ।

३. गर्भिणी महिलाले महिना महिनामा घुम्ती क्लिनको बेलामा आफ्नो स्वास्थ्य जाँच गराउन पर्दछ । बसेको

आमाको स्वास्थ्य कार्ड

PRENATAL CARD

ईलाका : .... गा.वि.स. .....

नाम : .....

पतिको नाम : .....

वार्ड : ..... घर नम्बर: .....

गाउँ : .....

Save the Children US

गर्भको विवरण

Para-

Gravida-

पछिल्लो महिनावारी
Last Menstrual Date

आमाको उमेर
Mother's Age

प्रसवको अनुमानित मिति
Expected Date of Delivery

महीना Month	मिति Date	वजन Weight (Kg)	रक्तचाप B.P.	सुन्निएको Oedema	पिशाबमा आल्बुमिन Albumin in Urine	पिशाबमा चिनी Sugar in Urine	बच्चाको हृदयगति Fetal Heart Rate	सोझो, उल्टो, तेर्सो Presentation Position	समस्याहरू Problems/Complaints	उपचार र सल्लाह Treatment and Advice	सही Signature
1											
2											
3											
4											
5											
6											
7.											
8											
9											

बच्चा जन्मेको मिति
Date of birth

लिङ्ग
Sex

बच्चा जन्मदाको वजन
Weight of baby

बच्चा जन्माउन सहयोग गर्ने व्यक्ति
Delivered by

प्रसुति पश्चात भेट गरेको मिति
Date of post-natal visit

सुझाव
Comments

Appendix C (Y)

HIS MAJESTY'S GOVERNMENT POLICY ON CONTROL OF DIARRHOEAL DISEASES PROGRAMME

1. Recognizing diarrhoeal cfiaeases as one of the major public health problem among children under 5 years of age in Nepal, the National Control. of Diarrhoeal Diseases programme (NCDDP) will be accorded priority status by HMG and shall remain us an integral part of the Primary Health 'Care system.

2. Improvement in diarrhoea, case management will be used as a primary strategy for reduction of.mortalfty due to diarrhoea among children under 5 years of. age,

3. Effective diarrhoea case management will be provided in the health ihstitutions by establishing ORT corners in all hospitals, primary health'centres and health posts throughout. the country.

4. All health facilities and community health volunteers will serve as the primary providers of ORS.

Effective case management at home level

1. For the prevention of dehydration, the use of recommended home fluids such as rice gruel, bean soup and vegetable soup with some salt, will be promoted. The fluid should be as thick as possible while still being drinkable . In 'case recommended home fluid is not: available plain water may be given. Similarly, the use of ORS will be encouraged at home level Per effective diarrhoea case management. The exact volume of ORS solution to be administered after each loose motion will Se determined as per WHO's Marragoment of the patient with Diarrhoea Chart.

2. An exclusively breast-fed child should continue to be given breast nri 1 k only. If the children are under 6 month of age and are partially/not, breast-fed, and are not taking solid foot1, the milk or formula should. bediluted with an equal amount of water for 2 days.

In the case of 6 months or older children who are already taking solid food;: they should receive cereal or another starchy food mixed with pluses, vegetable, and meat, fish, or egg, if possible. To make it more energy-rich, 1-2 teaspoonful of oil should be added to each serving. Administration of fresh fruit juicee'and bananas should be recommended becauee they are rich in potassium.

Use of high-f'ibre or bulky foods, very thin soups andfoods

containing a lot of sugar should be avoided.

The child should be encouraged to take as much as he wants. Generally, food sltoud be offered 6-times a day. After diarrhoea stops, one extra meal for the next two weeks should beprovided to the children. Children who have had persistent diarrhoea should be given an extra meal each day for atleast a month. Undernourished children should be given extra food until they reach normal weight for height.

3. Family members should. bring their children to the nearest health facility, community health worker or community heal th volunteer if the children have any of the following signs: passes many watery stools, repeuted vomiting, marked thirst, eating or-drinking poorly, fever, blood in stool or seems not to be getting better within 72 hours after receiving case management at home level.

Cape management at health facl ities

All cases with no dehydration or some dehydration referred to the sub-health posts, health posts, primary health centres os hospitals will be assessed and will receive OHS (Free of Cost) depending on degree of dehydration as per WHO's "Management of the patient with Diarrhoea" chart.

Intravenous

All children with sign of severe dehydration will be giver) Ringer's lactate solution intravenously, but, if this is not available, other acceptable i.v.solution would be normal saline, half strength Darrow's solution and half-normal saline 5% dextrose, Usc of unsuitable solutions like plain glucose anddextrose **should be avoided.**

Diarrhoea Training Unit (DTU)

One DTU in each regional hospital and one at central level, Kanti Children Hospital, Kathmandu will be established on a phased basis by 1995.

Oral Rehydration Therapy (ORT) Corners- will be established phase-wise in each health post, primary health centre and hospital in order to provide effective case management in each health institution.

Advice

All mothers should be taught: to give a child with diarrhoea increased fluids and to continue to feed the child, and how to prepare and give ORS solution. In addition to recommended home fluid, (rice gruel, vegetable soups and bean soups with some salt), information should also be given on other suitable fluids Like fruit juices, or plain water.

Advice should also be given to mothers about when to seek medical &ice for her child suffering from diarrhoea.

Messages regarding personal and domestic hygiene, exclusive breast-feeding, improved weaning practices, use of safe water use of a latrine and measles immunization should always be emphasized on every possible occasions.

Oral Rehydration Salts (ORS), (Jeevan Jal) Packets

Jeevan Jal packets of one liter size and formula conforming to WHO recommendations, with quality control provision, will be manufactured in the country. Import or local production of ORS not conforming to the WHO formula will be banned. ORS solution will be given at household and health facility Level to diarrhoea cases with some signs of dehydration, who are able to drink and are not severely dehydrated.

Jeevan Jal will be made available free of cost in all health institution. Health volunteers, however, will continue selling it at a nominal price fixed by HMG.

In order to make ORS packets widely available all drug stores, public or private, NGOs, social and voluntary organizations various forms of general and grocery strops will be encouraged to actively participate in its sale and distribution system.

Rational use of drugs

a) Antibiotic or anti-parasitic drugs

The routine use of antibiotics and antiparasitic drugs in acute watery diarrhea is not appropriate and should be avoided. Their indiscriminate use may increase resistance of some disease causing organisms to antibiotics.

The selective use of antibiotics is indicated in cases Of

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choirea and dysentery (blood in stool), and antiparasitic drugs for intestinal amoebiasis and giardiasis as per WHO's Management of the patient wi th Diarrhoea Chart.

Neomycin/Streptomycin nnd non/absorbable sulfonamides such as sulfaguanidine, succinyl- sulfathiazole and phthalylsulfathiazole.

b) Anti-diarrhoeal drugs

Disease Surveillance:

Disease surveillance mechanism will be further strengthened with close cooperation with the Division of Epidemiology by impacting suitable training on reporting for all focal. points responsible for CDD at regional, district, primary health centres and health' posts level. NCDDP will analyse the data and disseminate information to the concerned health institutions.

Outbreaks :

Timely preventive measures against epidemic outbreaks will be planned and implemented in close cooperation with the Division of Epidemiology and central and *regional* laboratory services.

Anti-diarrhoeal drugs :

No antidiarrhoeal drugs should be given *to* children as they are ineffective and some are even harmful. Drugs that should not be given children are: ***Loperamide,*** dighenoxylate hydrochloride, hydroquinolimcs, kaolin, pectin, charcoal, smectite/attapulgite.

Import or production of such antidiarrhoeals for the treatment of diarrhoeal diseases within the country will be discouraged and with the assistance of Department of Drug Adminstration (DDA) will be banned gradually . Similarly, the use of glucose powder and sugar salt solution (SSS) in the management of diarrhoea will be discouraged.

Prevention of diarrhoea:

Most important nnd feasible preventive measures for the control of diarrhoeal diseases *are* : exclusive breast-feeding for first 4-6 months of age, proper weaning practices, hand washing, use of clean water, use of latrines, safe disposal of. childrens' stools *and* measles immunization.

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The National Control of Diarrhoeal Diseases Programme will intensify its collaboration with other governmental, non-governmental and relevant professional organizations responsible for planning and implementation of preventive interventions in relation to health education, nutrition and water and sanitation.

Since control of diarrhoeal diseases programme demands multisectoral approach, HMG/Nepal has decided to formulate the following committees for ensuring better coordination and support from all relevnnt agencies:

1. National Committee on Control of Diarrhoeal Diseases Programme will be constituted under the chairmanvbip of' Hon'ble Health Minister with proper representation of relevant ministries and agencies.

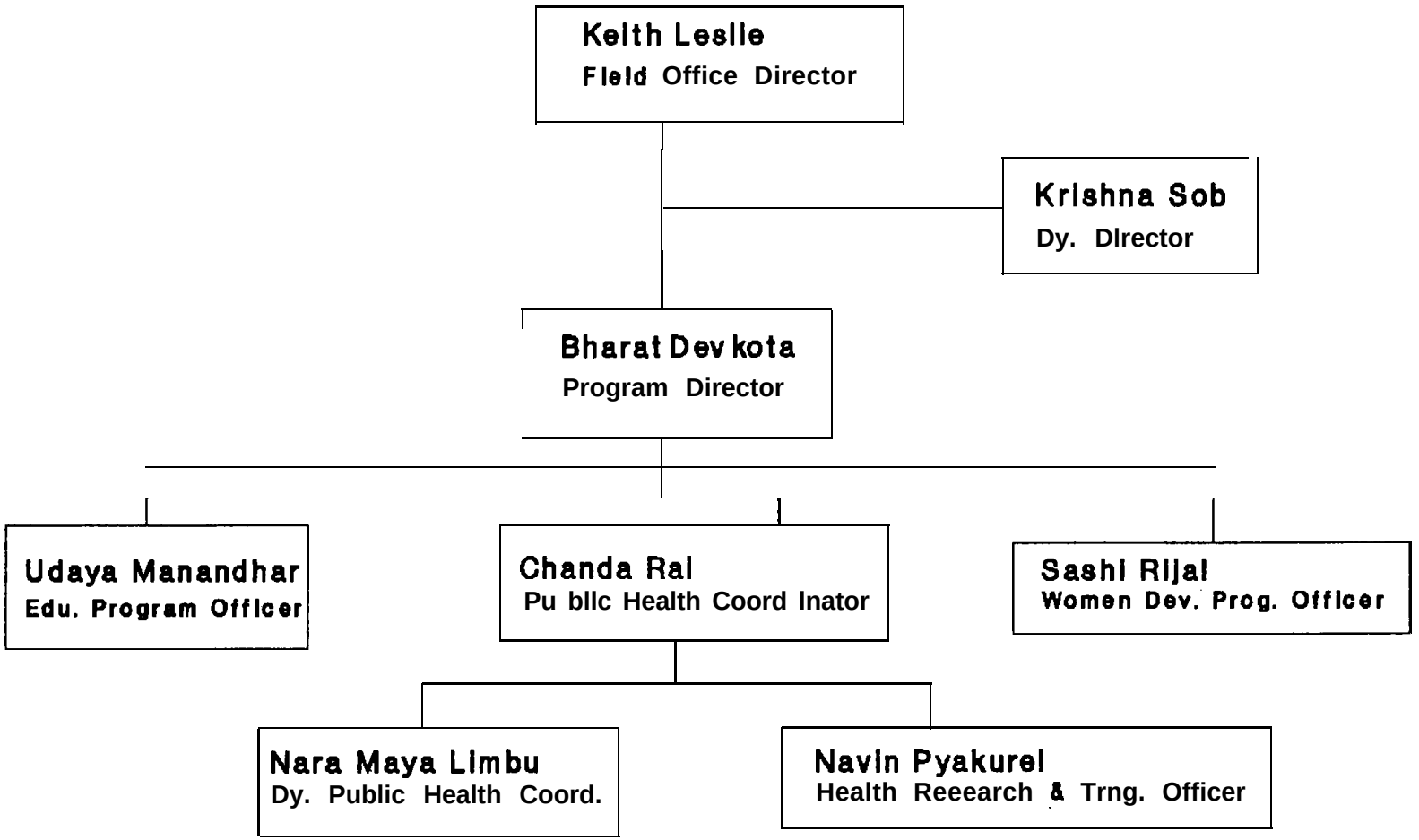
2 District level Coordination Committee will be formed which will be chaired by the Chairman of the district development committee with district-level social and voluntary organizations as its members and the officer - in-charge of the district health services as a member-cum-secretary for enforcing improved participation at district level,

3. Electoral constituency level coordination committee will be formed under thepatronageof the respective Member of Parliament representing a particular electoral. constituency with active participation of the chief of the primary health centre as Member-Cum-Secretary nnd volunLary and community leaders thereby ensuring community participation of the programme.

education:

Undoubtedly, health education has an important role 'to play in the MCDDP. Keeping in mind tklc diversity Of languages/dialects, culture, behavioural aspects and geographical features, strong health education activities on a national scale will be launched utilizing all available tools. Any organization interested in the production of health education materials or conducting such programmer will' be given priority. In order to maintain consistency and uniformity in health education all messages will have to be approved by the Manager, National Control of Diarrhoeal Diseases Programme.

Save the Children/US
Organigram



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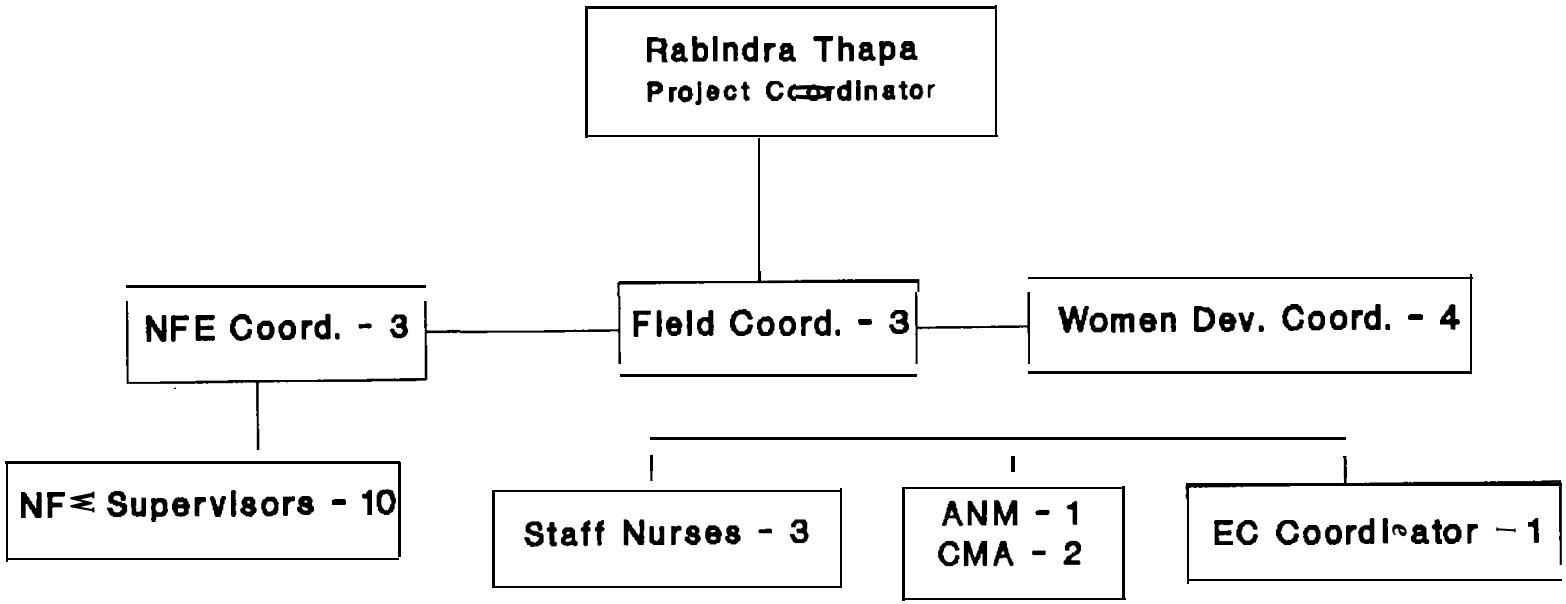
Appendix D

Save the Children, US
Organigram



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JOB DESCRIPTIONS AND BIODATAS

JOB DESCRIPTION: STAFF NURSE

The staff nurse will be based in Nuwakot. He/she will report edministratively to the Project Coordinator/Field Coordinator and sectorally to ths Public Health Coordinator in Kethmandu. The staff nurse will be responsible os follows:

1. Administrative:
A. To supervise CS VIII project MCH activities on regular basis.
B. To coordinate with Health Post staff and community members regarding MCH Outreach Clinics (ORC).
C. To assist the Community Health Volunteers (CHVs), trained Traditional Birth Attendants and Mothers Groups.

2. Program:
A. To work with health staff and other sector staff, District Public Health Office (DPHO)/HP staff, and community representatives to identify priority health needs and target groups for development of the CS 8 implementstion plan.
B. To assist health and other staff, DPHO/HP staff and community representatives in revising CS VIII objectives and target groups as needed.
C. To participate in preparation of quarterly plan for submission to Program Department.

3. Training:
A. To assist the IEC Coordinator in assessing the training needs of HP staff, MCHWs, CHVs and TBAs.
B. To assist the IEC Coordinator in planning, conducting, and evaluating training activities of HP staff, MCHWs. CHVs and TBAs.
3. To assist the Project Coordinator and IEC Coordinator with training of CHVs, TBAs, school teachers, Non-formal education (NFE) supervisors and facilitators and women's group leaders regarding CS messages.

4. Implementation:
A. To organize and supervise MCH ORC in collaboration with DPHO/HP staff, community representatives, CHVs and TBAs.
B. To assist the IEC Coordinator, Project Coordinator and other staff with conduct and supervision of health education and promotion activities.
C. To assist the Project Coordinator with strengthening the referral network at HP and District Levels in collaboration with DPHO/HP staff and community volunteers and representatives.

4. Monitoring and Evaluation
A. To assist the Project Coordinator with planning, implementation and evaluation of health surveys.
B. To prepare timely reports of project activities, including expenses.
C. To assist the Project Coordinator with collection, review and compilation of HP data and preparation of the quarterly report for submission to the Public Heelth Coordinator.
D. To participate in quarterly review of CS VIII project objectives.
E. To assist the Project Coordinator with preparation and presentation of period achievement reports to community groups and DPHO/HP staff.
F. To participate in midterm and final evaluations as needed.

JOB DESCRIPTION: NON-FORMAL EDUCATION COORDINATOR

The NFE Coordinator will be based in Nuwakot. He/She will report administratively to the Nuwakot Project Coordinator/Field Coordinator and sectorally to the Education Program Officer in Kathmandu. The NFE coordinator will be responsible as follows:

1. ADMINISTRATIVE
A. To advise the Education program Officer, Field Coordinetor and Project Coordinator on the overall direction and progress of CS 8 activities.
B. To coordinate with District Education Office, community representatives and Nuwakot field staff in planning, implementstion and evaluation of CS 8 NFE activities.
C. To consult frequently with the Coordinator and Project Coordinator regarding CS VIII NFE activities, including personal and financial matters.
D. To supervise the conduct of CS VIII NFE activities throughout llakas 1, 12 and 13.

2. PROGRAM

A. To facilitate identification of priority NFE needs of women for development of the CS VIII implsmsntetion plan in collaboration with District Education Office steff, Nuwakot-based program and administrative staff.

B. To assist DE0 steff. community representatives and project steff in revising CS VIII NFE objectives as needed.

C. To perticipate in preparation of CS VIII quarterly plan submission to the Program Deportment.

D. To advise the project staff regarding technic81 NFE issues, ensuring that project interventions ore technicelly accurete and appropriete.

E. To coordinate snd supervise the implementetion of CS VIII NFE ectivities in colleboration with SC/US, Kathmendu.

F. To collaborets with the IEC Coordinetor, Project Coordinetor and Education Progrem Officer in the development of NFE materials thet communicate child survival messages.

G. To assist CS VIII project steff with supervision of NFE supervisors' end facilitators' presentation of child survival messages to NFE classes.

H. To promote and fscilitete development of linkeges with releted government and development agencies in Nepal.

I. To develop, conduct end evaluate training for NFE supervisors and fecilitators.

J. To nssist the IEC Coordinator with the planning, conduct end evaluation of communication skills treining for NFE supervisors and fecilitators.

K. To assist the Project Coordinator with design and conduct of surveys and evaluation activities for documentetion of the quelitetive end quantitetive impsct of the CS VIII NFE activities.

L. To prepere querterly summery of NFE activities, including expenses for inclusion in querterly report.

M. To perticipete in querterly review of CS VIII project objectives.

N. To perticipate in preparation and presentation of periodic project achievement reports to community groups.

0. To perticipate on the CS VIII midterm and final eveluetion teams as necessery.

JOB DESCRIPTION: WOMEN DEVELOPMENT COORDINATOR

Under the direct supervision of Project Coordinator/Field Coordinetor. the Women Development Coordinetor will be responsible for the following:

1. Administration

A. Maintain up-to-dote records end files of the Women Development program in the specified Ileke.

B. Report to the Project Coordinator/FCO immediately ebout the happening or incidents within the impect areas with possible suggestions.

C. Submit quarterly program schedules and reports to Project Coordinator/FCO for KTM/Program.

D. Work closely with Project Coordinator/FCO end other steffs.

E. Esteblish linkege with concerned district/village development committees level agencies.

2. Progrem

A. Build-up repport end trust with local communities through home visits, formel and informal meetings.

B. Study and identify the situations, problems end interests of women concerning heelth, educetion. agriculture, home management science, forestry and small entrepreneurships.

C. Identify potentiel; group or individual program/project to benefit community/individuel.

D. Encourage women perticipants of NFE as much as possible to perticipate in the women development program.

E. Observe and study the NFE progrem women problem in general and their interest in specific areas of health, educetion, egriculture, home manegement science, forestry end individual/group entrepreneurs.

F. Develop the leadership qualities among females end encourege them to participate ectively in community decision making process.

G. Identify the poor mothers nnd work with them to improve their overell finencial stntus.

H. In consultetion of Sr. PM/Sr. FCO identify feasible income generating ectivities for the NFE participants end Women's Group.

I. Organize/coordinate trainings/orientations for Women Development Assistants, Women's Groups.

J. Make annual sectoral planning for the Clusterlllaka.

K. Identify the treining needs for women to improve their existing skills end other enterprising skills.

3. Implementation

A. Provide trainings/orientations to WDAs, Women's Groups, NFE facilitators and supervisors.

B. Orgenize small groups of women to implement menageable projects such as, kitchen gerdens, livestock reising, child care, sevings, post-literary, horticulture etc.

C. Involve and encourege, VDC end WSC and community people to support Educetion end Women Development programs.

D. Hold regular meetings with field staffs, VDC end women to discuss end initiate women development ectivities.

E. Supervise the on going Education end Women Development activities.

F. Coordinate the women program with other sectoral program activities.

G. Coordinete the Women's Groups with other service centers eveileble in their communities and encourege them to make on use of them for instence TBA, non-formel adult education, out of school children program, child core end other activities, veterinary services, banks, P.C.R.W., S.F.D.P., egriculture service centers etc.

4. Monitoring and Eveluation

A. Meke an action research to explore the existing skills of women end improve them.

B. Assess the training needs of Women Development Assistents. Women's Groups.

C. Help/train the WDAs/Women's Groups to compile monthly progress reporting formets.

D. Make evaluation of Education end Women's Group activities as required.

E. Make regular supervision of Education and Women Development programs.

F. Regulerize the Educstion end Women Development progrems sccording to ssctorel policy.

G. Attend VDC/WSC sectors1 and program releted meetings as and when necessary and precticeble; perform other duties as and when necessary; ettend meetings and travel whenever necessary with the approval of Sr. PM/Sr. FCO of your areas.

JOB DESCRIPTION: PROJECT COORDINATOR

Project Coordinetor will be the SC Heelth Officer besed in Nuwakot. He/she will report administratively and sectorelly to the Public Heelth Coordinetor in Kethmandu.

The Project Coordinetor will be responsible es follows:

1. Administrative

A. To advise the Public Health Coordinetor end Educetion Progrem Officer on the overell direction of the project.

B. To manege the CS VIII grant progremmeticelly end edministretively in consultetion with the Progrem Director, Public Heelth Coordinetor. Education Program Officer and Field Coordinators.

C. To coordinete with DPHO/HP steff, community lenders end members end SC Nuwakot field staff in plenning. implementation and evaluation of the CS VIII project in close colleboration with the Field Coordinetors.

D. To coordinete regular meetings with Nuwakot Field Coordinetors and sectornl heeds regerding intersectoral coordination for CS VIII project activities.

E. To supervise the conduct of CS VIII project ectivities in Nuwakot.

F. To ensure finenciel eccountebility for project funds spent in Nuwekot.

G. To prepare CS VIII quarterly report submitted to SC/US home office end USAID with assistance from Public Heelth Coordinetor.

H. To assist the Public Heelth Coordinetor with preparation of the annual CS VIII project reports submitted to SC/US home office and USAID.

2. Progrem

A. To coordinate identification of priority heelth needs and terget groups for development of the CS VIII implementetion plen with District Public Heelth Office (DPHO)/HP steff, community representatives end SC's Kathmendu and Nuwekot based program end administretive staff.

B. To assist health and other sector steff, DPHO/HP staff and community representetives in revising CS VIII objectives and target groups as needed.

C. To facilitate quarterly updating of CS VIII plan for submission to Program Deportment, in consultetion with Public Health Coordinator/Dy. Public Heelth Coordinator.

D. To collaborete with the Trsining Coordinator in planning a treining program for the ongoing development of CS VIII project steff.

E. To advise the project staff regerding technical heelth issues, ensuring that project intervention are technically sccurete and appropriete.

F. To coordinate end supervise the implementation of CS VIII project activities; collaborating with Kethmendu- and Nuwakot-based program and administrative staffs.

G. To visit the project areas throughout llekes 1, 12 and 13 frequently to facilitate the joint implementation of the project with government staff.

H. To promote and fecilitate development of linkages with releted public heelth and development agencies in Nepal.

I. To colleborete with the Heelth Research/Training Officer on the development, conduct end evaluation of training courses for the project steff, government steff, and community members.

J. To collaborate with IEC Coordinetor regsrding the treining of CHVs, TBAs, school teschers. Non-Formel Education (NFE) supervisors and fecilitators end women's group lenders regerding heelth educetion end promotion messages.

K. To facilitate quarterly review end revision of CS VIII project objectives and workplen in consultation with the Kathmendu and Nuwekot field staff, end DPHO/HP steff.

L. To prepare timely reports of project activities, including expenses.

M. To coordinete the collection, review snd compiletion of HP deta for preperetion of the Nuwekot Health Program quarterly reports submitted to the Public Heelth Coordinator.

N. To prepere CS VIII quarterly reports submitted to SC/US home office and USAID with essistance from the Public Heelth Coordinator/Dy. Public Health Coordinetor.

0. To assist the Public Health Coordinator with preparation of CS VIII annual reports submitted to SC/US home office and USAID.
P. To coordinate the preparation and presentation of periodic achievement reports to community groups and DPHO/HP staff.
Q. To assist the Public Health Coordinator with the design and conduct of CS VIII surveys and evaluation activities.
R. To participate on the CS VIII midterm and final evaluation teams as necessary.

JOB DESCRIPTION: RESEARCH AND TRAINING OFFICER

The training officer will be based in KTM and 50% of his time will be spent preparing training curriculum, material, manual, coordinating training program and training various level health staff of Save the Children and Government Health staff, the non-formal education staff in SC/US working areas. The research and training officer will report to Public Health Coordinator in KTM and will be responsible as follows:

- **prepare small research package for innovative health activities which could be replicable in National context.**
- **to be responsible for assessing training need and designing training program for new staff and volunteers maintaining quality of work in health in sector in SC/US working areas.**
- **to prepare plan of training programme for the ongoing development of health staff.**
- **to assist Education Officer, CS VII Project Coordinator, MCH Coordinator and Health Officer to plan and cooperate training programs, particularly in strengthening the PHC component & the SC/US NFE program.**
- **design baseline studies, evaluation studies etc. on health sector.**
- **to assist Public Health Coordinator to develop plan to produce training manuals, materials, equipments and audio-visual aids and data analysis of health surveys.**
- **assess the research need in health sector.**
- **to coordinate training activities with the MCH Coordinator, Health Officer, Public Health Coordinator, Women Development Officer and Education Program Officer on a quarterly basis.**
- **to liaise with the Non-Formal Education, Agriculture and Infrastructure sectors in health related training activities.**
- **to give technical input to the CS VII Project, and Non-Formal Education Program in order to ensure quality of health education activities.**
- **to organize and implement training courses for various level of health and other sectoral staffs, including NFE supervisors and facilitators.**
- **to visit all SC/US working areas on a regular basis to guide and support health staff and ensure the quality of their work.**
- **to assist in expanding the SC/US training projects for HMG and other Nepali NGO staff.**
- **to assist health staff to write health program project proposal.**
- **to develop training curriculum for training courses particularly related to health issues.**
- **to provide refresher training to SCF health staff.**
- **to provide training to other SCF staff of other sectors in health issues.**
- **prepare a plan to best utilize the Facts For Life in SC/US Health program.**
- **design and conduct research studies in health sector and other related sectors.**
- **to assist PHC to analyze quarterly report.**
- **to compile and write report of health activities and give comments, recommendations to the Public Health Coordinator, KTM.**
- **to design and assist with health surveys.**
- **to prepare evaluation tool for each training conducted and implement to conduct impact evaluation of different training programs as per their need.**
- **to supervise the program in all aspects of Public Health.**
- **to monitor regularly various health activities.**

JOB DESCRIPTION: DEPUTY PUBLIC HEALTH COORDINATOR

Deputy Public Health Coordinator based in Kathmandu will be responsible to assist Public Health Coordinator for the management of health sector activities for the agency and will work under the direct supervision of Public Health Coordinator/Program Director. Job responsibilities are as follows:

- **assist public health coordinator to establish and maintain health sector policies in SC/US project areas.**
- **assist public health coordinator to interpret and resolve issues which cannot be solved in the project areas by the field team.**
- **assist public health coordinator to coordinate and arrange for resource persons and work with other organizations.**
- **advise PH coordinator, program director re: health staff management and monitor and review sectoral budget on a quarterly basis.**
- **assist public health coordinator to design health and child survival programs to support and to coordinate with Government and other sectoral programs i.e., NFE, women's group, mother's group, farmer's group, etc.**

- assist program team to review and prepare annual plan for each Ilaka Office in health program.
- identify and design integrated projects in collaboration with other sectoral staff.
- assist in preparation of annual work calender and quarterly objectives.
- identify, plan activities to support Ministry and local NGOs.
- review work plan and staff objectives with Ilaka Incharges on a quarterly basis.
- identify innovative. cost effective and sustainable program: test and assist for implementation.
- identify and promote new ideas, concepts or pilot projects and disseminate findings for the further improvement and replication.
- locate and create linkages with training and resource agencies.
- assist field team to implement the identified programs for ilakas.
- assist public health coordinator to design sectoral monitoring system, share with Ilaka Incharges and assist to implement it.
- assist public health coordinator to provide guidance and support to Nuwakot and Dang health program.
- assist program team to prepare quarterly and semi-annual reports of health activities for HMG, USAID and Westport.
- write reports on specific topics as per the need.
- visit field at least every six weeks.
- assess the training needs of the health workers specific to MCH component.
- guide and support field team to conduct quality training program and evaluate each and every training program.

JOB DESCRIPTION: IEC COORDINATOR

IEC Coordinator will be under direct supervision of Project Coordinator. He/she will be responsible for Ilakas 1, 12 and 13 as follows:

- to coordinate with Health, NFE, Productivity and AIDS sectors in identifying priority IEC needs.
- to prepare quarterly targets and plans (IEC) and submit to Project Coordinator for Program Department, Kathmandu.
- to coordinate with other sectors and RTO to design research studies related to IEC.
- to help assess other sectors in identifying training needs for community groups.
- to carry out communication research studies related to CS VIII and AIDS.
- to assist RTO in designing IEC strategy.
- to implement various communication campaigns and provide supervision for different promotional activities.
- to assist other sectors in providing trainings to community groups, volunteers and representatives.
- to develop, pretest and produce different IEC materials as well as ensure proper use with the technical support of HRT Officer.
- to keep updated records of every IEC activities.
- to assist Project Coordinator in analyzing the quarterly achievements as against targets.
- to carry out evaluation of IEC materials developed in coordination with other sectors.
- to participate in the CS VIII midterm and final survey as and when necessary.
- to assist Project Coordinator and RTO in identifying training needs to staff members.
- to provide on the job trainings to other staff in relation to IEC.

JOB DESCRIPTION: CMA/ANM

Under the direct supervision of the Staff Nurse and administratively under Project Coordinator and ilaka in-charge, the CMA's main roles and responsibilities will be as follows:

- In the absence of staff nurse, CMA has overall responsibility of implementing the health program in accordance with SCF policies.
- Supervise and maintain contacts with every CHVs/VHWs on a regular basis and give guidance in their activities. Also keep record of the work of each VHWs.
- Maintain and supervise central Family Health Records reported by VHWs.
- Assist staff nurse to plan the health program activities.
- Design quarterly workplans/objectives, review with supervisors end submit to Program Department.
- Plan the village level health meetings and health training for CHVs.
- Conduct the village level health meetings and health training for CHVs.
- Undertake routine field visits with VHWs on field visit deys.
- Provide primary health care services on thru Outreach clinics as well as in case of emergency situations.
- Identify severely malnourished children under-5 and monitor their condition with the help of VHW.
- Motivate the parents in immunization of the children and cooperate in setting-up immunization camps.
- Organize and conduct trainings for CHVs/VHWs.

. Carry out health educational activities for families and community.
. Help in preparing quarterly reports.
. Assist staff nurse in reporting and recording specific activities.
. Participate in survey/research activities relating to health.
" Help to provide periodic achievement reports to VDCs and other concerned groups.

JOB DESCRIPTION: ASSISTANT ACCOUNTANT (FIELD BASED)

Under the supervision of Account Officer or Ilaka Incharge (whoever is applicable), will be responsible for the following activities:

1. Handle Petty Cash Fund properly. This task includes: Maintain petty cash register; Pay the bills not exceeding Rs. 500/-; Provide advances for the project activities; Make sure that the supporting documents duly approved by the responsible official are available before payment is made or an advance is provided; Recuperate the advances provided within seven days after the completion of the required activities.
2. Monthly Salary Distribution. This task includes: Prepare monthly salary receipts to pay the local contract staff: Write a cheque, draw money from the bank and distribute among the staff properly.
3. Handle Banking Transactions efficiently: This task includes the following activities: Write cheques and draw cash from the bank; Deposit draft and cash received; Maintain cash book properly; Prepare required vouchers to reflect the bank transactions: Obtain bank statement from the bank every month on time; Prepare Bank Reconciliation Statement; Correspond with the bank if needed.
4. Prepare vouchers end write cheques, deliver the cheques written to the respective parsons/places.
5. File the vouchers in proper index files and keep them safe in the specified place. Also, file other memo letters, financial statements, etc. properly.
6. Perform any other necessary financial duties to assist the Account Officer whenever required.
7. Whenever Account Officer is out or in the Ilaka where an Account Officer is not assigned, take his/her responsibility.
8. Travel to Kathmandu or Gorkha/Siraha or any other places when required.
9. Produce any financial statements, bank balance, or other financial records whenever asked by Ilaka Incharge or Kathmandu Office.
10. Maintain confidentiality.

The job description for the Accountant in Nuwakot will heve to be revised for the following reasons:

1. There will be a centralized accounts system in Nuwakot.
2. Nuwakot program is funded by 2 grants: CS VIII and WHO apart from SC private fund.

CURRICULUM VITAE: WANDA RAI

EDUCATIONAL BACKGROUND:

1. M. S. in Community Health Nursing, Russell Sage College, Troy, New York, U.S.A., 1988. Thesis - "A study of effectiveness of Traditional Birth Attendant - Training in Improving Maternal and Child Health Care knowledge of TBAs."
2. Bachelor of Science in Nursing: American University of Beirut, Lebanon, 1982.
3. Teaching Diploma: American University of Beirut, Lebanon, 1982.
4. Bachelor of Arts: Tribhuvan University, Kathmandu. Nepal, 1977

TRAINING/WORKSHOPS/SEMINARS:

1. International Training on Development and Management of Community Based Family Planning. Health and Development Programs - The Asian Center, Bangkok, Thailand, 1985
2. PVO Child Survival Lessons Learned Conference - Community College in Shiprock. New Mexico, USA, 1992.
3. Asia Pacific AIDS & STD Conference - New Delhi, 1992

WORK EXPERIENCE:

1990 May-Present: Public Health Coordinator, Save the Children US

Prepare and revise health program guideline. Plan and prepare health programs. guide and ensure quality of health staffs' and Social Marketing staffs' work. Strengthen integration of health sector with other sectors. Adjust staff structure with consultation of Director, Program Director, Health Officers, MCH Coordinator and Cluster Incharges. Coordinate health programs with Ministry of Health, International and National non-governmental agencies and District Public Health Offices. Develop and organize training curriculum and Training programs for various levels of health staff. Guide and support for the establishment of new health programs.

Design health and Social Marketing programs to support and coordinate with other sectoral programs i.e. non-formal education, women groups, mothers groups and farmers groups etc. Plan and guide regular health and social marketing meetings. Provide regular monitoring for various health activities. Establish functional health information system in Save the Children USA working areas.

1982 - 1990: Nurse administrator, Division of Nursing, Ministry of Health, Nepal.
Plan and prepare programs for nursing staff development and MCH service improvement. Implement, prepare all training material and monitor the national MCH Worker Training Program. Support, guide and supervise field level health workers. Assist Chief of tha DON in policy making. Prepare research draft on Nursing services in country. Plan and coordinate with other NGOs on MCH care activities in the country. Prepare project proposals for National and International Agencies.
1988: Research Assistant, Harvard Medical Study Review, Utilization Information Service Division of the Hospital Association of NYS.
1978 - 82: Staff Nurse, Division of Nursing, Nepal.
1976 - 78: Staff Nurse, Bharatpur Hospital, Bharatpur, Nepal.
1972 - 76: Staff Nurse, Gorkha Hospital, Gorkha.
1971 - 72: Staff Nurse, Bheri Zonal Hospital, Nepalgunj, Nepal.
PUBLICATIONS:
1. Traditional Birth Attendant's Trainer's Manual (Nepali) (TBA Training Kit).
2. Maternal & Child Health Worker's Training Manual (Nepali).
3. Health Facilities Infection Control Training Manual (English & Nepali).
4. Management of Nursing Services by Standards (English).
5. A Handbook for Auxiliary Nurse Midwives (Nepali).

CURRICULUM VITAE: NARA MAYA LIMBU (SUBBA)

EDUCATIONAL BACKGROUND
Passed S.L.C. from Dharan Depot High School, Sunsari with Second Division - Year 1969
Passed Certificate in Nursing (Additional Course) from Mahaboudha Nurse Campus, Kathmandu with Merit. Year 1979.
Passed Intermediate in Arts (I.A.) from Private, Tribhuvan University, Kathmandu, second division. Year 1979.
Undergone through Ward Sister Course from R.A.K. College of Nursing, New Delhi, India. Division - Merit. Year 1976.
Completed Diploma in Nursing Education from R.A.K. College of Nursing, New Delhi, India. Division - Merit. Year 1976.
Completed Diploma in Midwifery. from Mahaboudha Nurse Campus, Tribhuwan University. Kathmandu. Division - Merit, Year - 1981
Completed M.Sc. (Study of Health Development), from Chulangkorn University, Bangkok, Thailand. Division - G.P.A. Year - 1991

WORK EXPERIENCE:
Nov. 1973 - April 1975: Assistant Instructor, Bharatpur A.N.M. Campus, Chitwan.
April 1975 - Nov. 1979: Assistant instructor, Biratnagar A.N.M. Campus, Morang.
Nov. 1979 - Nov. 1982: Deputy Instructor, Biratnagar A.N.M. Campus, Morang.
Nov. 1982 - Dec. 1986: Assistant Lecturer, Biratnagar Nursing Campus, Morang.
Dec. 1986 - July 1991: Campus In-charge, Tansen A.N.M. Campus, Palpa.
July 1991 - Oct., 1992: Assistant Lecturer, Maharajgunj Nursing Campus, Maharajgunj, Kathmandu.
Oct. 1992 to date: Deputy Public Health Coordinator, Save the Children US, Maharajgunj, Kathmandu.

CURRICULUM VITAE: NAVIN K. PYAKURYAL

EDUCATIONAL BACKGROUND:
1991 - 92: International Institute of Population Sciences, Bombay Diploma in Demography with Outstanding Grade and First Position
1976 - 79: Tribhuvan University, Kathmandu, M.A. in Economics with Statistics & Demography.
July 1990: AIDS Prevention Project, Workshop on AIDS education.
August 1985: MCH Unit, FPIMCH, Kathmandu Training on MCH Services.
June 1983: UNDP/Development Training & Communication Planning (DTCP), Bangkok, Training on Programme Management.
May - Aug 1981: UNFPA. DTCP and FPIMCH, Kathmandu Population Communication, Training Planning Course.

WORK EXPERIENCE:
October 1992 to date: Health Research & Training Officer, Save the Children US, Kathmandu

Planned, conducted and prepared report of survey on knowledge/ attitude regarding AIDS/STDs and safe sax practices in Nuwakot District. Planned and conducted training on Focus Group Research in Siraha district as well as designed FGD topic guides on components of PHC.
1990 - 1991: IEC Consultant, Save the Children US, KTM. Developed, pretested and produced pictorial materials on oral pill, condom and diarrhea for the Sales Agents and clients of USAID funded contraceptive Social Marketing Project (CS-3) in Gorkha.
1987 - Ott 1992: Training Officer, FP/MCH Division, Ministry of Health. Kathmandu, Nepal. Planned clinical trainings on Injectable Contraceptive, Copper-T, Norplant and Surgical Sterilization for Doctors and Paramedicale as well as executed those trainings. Worked as Core Treiner in the training of Program Managers on Health System Research. Developed and tasted curriculum and other training materials. Planned and conducted training/ Workshop on curriculum development and training planning.
1980 - 1987: IEC Officer, FP/MCH Division, Ministry of Health, Kathmandu. Nepal. Planned national communication programs on family planning/ Population education and executed them. Developed, pretested and produced IEC kit for field extension workers. Developed, pretested and produced pictorial materials for illiterate people under Johns Hopkins University/PATH supported project. Design and conduct training of trainers on Population and Family Planning Education.

CURRICULUM VITAE: RAVINA THAPA

EDUCATIONAL BACKGROUND:
Certificate in General Medicine, Tribhuvan University, Institute of Medicine, Maharajgunj, 1981, 2nd Division.
Bachelor of Public Health, Tribhuvan University, Institute of Medicine, Maharajgunj, 1988, (1 st Division) on scholarship from SC/US.

WORK EXPERIENCE:
1. Trainee Health Assistant in Save the Children US, Takukot from October 1983 to March 1984.
2. Health Officer Save the Children US, Gorkha.

TRAINING:
1. "Leadership Development Course in Community Health",6 weeks, 1984, conducted jointly by Asian Health Institute (Japan) and Deenabandhu, Tamil Nadu, India.
2. Community Organization in Health Care, 1 month, 1985, Asian Health Institute, Aichi Prefecture, Japan.
3. Secondment to Save the Children (UK) for six weeks, 1990 for "Training and Communication Skills Training". Management of training courses under the supervision of Prakash Koirala, Training Coordinator. Curriculum Planning Resource Person on the "Communication Skills training in Chautera".

RESEARCH & PUBLICATIONS:
1. "Mobilizing Woman in Health Care Activities" Asian Health Institute Newsletter, Japan, 1986.
2. "District Health Profile", Parse District, 1987 in conjunction with Navin Shrestha.
3. DPT vaccination defaulters, 1988.
4. Baseline Surveys (economic, health, education, agriculture) in 4 panchayats of Gorkha District, 1989.

CURRICULUM VITAE: RAGHU THAPALIA

EDUCATIONAL BACKGROUND
- Master's Degree in International Administration, Program in Intercultural Management, School for International Training, Brattleboro, Vermont, USA, May 1991.
- Bachelor's Degree in English Literature & Economics, Tribuvan University, Kathmandu. Nepal, March 1987.

WORK EXPERIENCE
- Monitoring Officer (Jun 1991 to Present), Save the Children USA, Kathmandu, Nepal.
- Graduate Intern (Mar 1990 to May 1991), Asia/Pacific Region, Save the Children's Headquarters, Westport, Connecticut, USA.
- Computer Room Manager (Sep 1989 to Feb 1990). School for International Training, Brattleboro. Vermont, USA.
- Computer Officer (May 1983 to Aug 19891, Save the Children USA, Kathmandu, Nepal.
- Administrative Officer (Sep 1982 to Apr 1983), N.L. World Trade Concern Pvt. Ltd., Kathmandu, Nepal.